PATIENT DIRECTED REQUEST

*Indicates a REQUIRED field.

Completion of this document authorizes the disclosure and use of health information about you.
Failure to provide all information requested may invalidate this request.

*Patient Name: ______________________ Medical Record #: ______________
*Address: ______________________ *Date of Birth: ______________
*City/State/Zip: ______________________ Phone: ______________

Where do you want the information sent? (This patient directed request is used only when a patient is asking for their own records or directing them to be sent to a third party.)

*Recipient Name:	*Recipient Phone:
*Recipient Mailing Address:	*Recipient Email (if applicable):

***Check Delivery Option:**	Paper Copy / Pick Up or Mail Providers Fax # ______________ E-Mail (Encrypted/Patient or Continuity of Care Only) ______________

***What records do you want? (Check appropriate boxes below):**
Location: ______________________

Date(s) of Service: ____ / ____ / ____ through ____ / ______________). Please specify: ______________
Mental health/Alcohol/drug treatment information

I authorize ______________________ to pick up my medical records.
***Signature:** ______________________
Patient/Parent/Conservator/Guardian) Date/Time

*Print Name: ______________ Relationship______________

Authorization to Release Medical Info

Adventist Health
PATIENT DIRECTED REQUEST
(05/23) – 8707F2916

PATIENT LABEL