CLINICAL PATHOLOGY ASSOCIATES

Service Quality Integrity

MEDICAL RECORDS REQUEST

NOTE: All medical records are in the custody of the facility where services were rendered. For example, at the hospital where you were treated. We must access the medical facility's system in order to get your records. Therefore, it may take 2 weeks to respond to your request.

1. PATIENT INFORMATION

_____

***Name Last** ***First** **MI**

_____

Other names to search (maiden, nickname, former names, etc.)

_____

***Address** City State Zip

_____

Insurance I.D. Cell phone or Other Primary Phone Number (including area code)

_____/_____/_____

***Date of Birth** (MM/DD/YYYY) ***Sex** Last 4 digits of Social Security Number

2. PLEASE INDICATE THE MEDICAL RECORDS REQUESTED:

***NAME OF HOSPITAL OR CLINIC WHERE SERVICES WERE RENDERED**	***DATE OF SERVICE (MONTH & YEAR)**	**NAME OF ORDERING PHYSICIAN**

3. PLEASE SELECT ONE OF THE FOLLOWING METHODS OF TRANSMISSION:

Send to *(enter **Name** if different from patient)*:_____

*By *(please mark **one**)*:

- ◯ Email address:_____
  (see instructions regarding email delivery)
- ◯ Fax number:_____
- ◯ Mail *(enter address if different from above)*:_____

My signature below authorizes Clinical Pathology Associates (CPA) to release the records containing Protected Health Information (PHI) I have requested. **TWO FORMS OF IDENTIFICATION MUST ACCOMPANY THIS FORM. See instructions for more information.**

_____ _____

4. *SIGNATURE ***DATE**

***Relationship**: ◯ self ◯ parent

_____ _____

***Printed Name** ***Initials** ◯ Legal Guardian (provide proof) ◯ Personal Representative (provide proof)

FOR MORE INFORMATION OR TO SUBMIT FORM:

Clinical Pathology Associates
PO Box 28770
Austin, TX 78755

Phone: 512-579-4000
Toll free: 877-608-8643
Fax: 512-222-0146

To submit the form online, visit:
www.clinpathassoc.com

***Indicates REQUIRED information** **ANY CHANGES TO THE INFO PROVIDED REQUIRES A NEW FORM**

Instructions for Medical Records Request Form

1. **Patient information**

   Information is for the person whose records are being requested. Name, address, date of birth and sex are **required**. Phone contact information, insurance ID number and last 4 digits of the SSN may be helpful in identifying the patient.

2. **Medical Records Requested**
   - The name of the hospital or clinic where you were treated is **required**.
   - The month and year the services were provided is **required**.
   - Provide the name of the doctor who treated you. This information may be helpful in identifying the records.

   If you are uncertain about the location or dates of service, call our office to verify.
   Phone **512-579-4000** or toll free **877-608-8643**

3. **Method of Transmission**
   - If the records are being sent to someone other than the patient, please enter the name of the person to receive the records.
   - Please indicate the preferred method to receive the records. Note: Email delivery requires the recipient to setup a password to access the medical records.
   - Please make sure you verify the email address, fax number or mailing address you provide.

4. **Signature**
   - All requests must be signed and dated. If the person requesting the records is not the patient, please indicate the relationship between the patient and the requestor. Legal Guardians and Personal Representatives must provide written documentation to prove the authority to access the records.
   - All requests must have the printed name and initials of the person signing the form.

   Every request must be accompanied by **2 forms of identification**. Copies of any 2 of the following are acceptable:
   - Driver's license
   - State identification card
   - Insurance card
   - Military ID
   - Social Security card
   - Passport
   - U.S. Tribal or Bureau of Indian Affairs ID card
   - Certification of Citizenship – N560
   - Employee Authorization card

NOTE: Please do not email the form unless you are using secure email. To submit the form online or use secure email, please visit www.clinpathassoc.com.