Consent for Release of Medical Information

The purpose of this letter is to request copies of my medical records as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations.

I was treated in your office between _____. I request copies of the following [or all] health records related to my treatment.

Records requested, _____

I understand you may charge a reasonable fee for copying the records but will not charge for time spent locating the records. Please mail the requested records to me at the address I have provided. If I have the records mailed, I may also be charged for postage.

I look forward to receiving the above records within 30 days as specified under HIPAA. If my request cannot be honored within 30 days, please inform me of this by letter as well as the date I might expect to receive my records.

Name (Print): _____

Signature: _____

Date: _____