



REQUEST AND PATIENT IDENTIFICATION

*Date request made: _____

*Urgency of request: Urgent Routine

*Preferred delivery method: Mail Fax Secure email

*Patient Name: (Last, First, MI): _____

Patient Alias (Last, First, MI): _____

*Patient's Date of Birth: _____

***DATES AND TYPE OF INFORMATION BEING REQUESTED**

Date range of information being requested:

All dates Last 2 years Other: _____

Type of Information being requested:

Consultation Reports Diagnostic Films Dosimetry Records Laboratory Results

Physician Notes

Portal Films/Simulation Films Progress Notes Radiology or Imaging Reports

Surgery/Pathology

Complete Medical Record Billing Records Genetic Records

Other (please specify): _____

REQUESTING HEALTHCARE PROVIDER'S INFORMATION

*Name of facility: _____

*Mailing address:

*Requester's name: _____

*Phone: _____ Fax: _____

Email: _____

*required

The HIPAA Privacy Rule permits a health care provider to disclose protected health information about an individual, without the individual's authorization, to another health care provider for that provider's treatment of the individual. See 45 CFR 164.506 and the definition of "treatment" at 45 CFR 164.501.