Provider 1ST

PATIENT REQUEST FOR MEDICAL RECORDS

Patient Name (please print clearly):____

Release Records from (Name of Doctor or Practice):____

Doctor or Practice Address:____

Purpose of the recordS:____

Date of Birth:____

Address:____ City:________________ State: _______________

Zip code:____________________________ Phone Number: ____

Email Address (required for electronic delivery option): ____

Information requested-Check all that applies:

☐ All health care information in my record (including immunizations, lab/pathology, and radiology reports)

☐ Immunization records only

☐ Lab/Pathology results only-date(s) or type(s):

☐ Radiology images only - date(s) or Type(s):

☐ Specific information only:

Delivery Options:

☐ I would like the records mailed to the above address.

☐ I would like electronic delivery of the records

_   _

Patient or legally authorized representative signature   **Date**

_   _

Relationship to patient   **Printed name if signed on behalf of patient**

FAX

Fax to:
(800) 818-2114

MAIL

Mail To:
P.O.BOX 54650
Irvine, CA 92619

@ **Email to:**
requests@provider1st.com

Questions call us:
(855) 514-2378