Baptist Health
all our best

Patient Request for Medical Records

Patient Name: _____ Date of Birth:_____

Phone Number_____ Last Four Digits of Social Security Number:_____

Address_____

Email Adress_____

As the patient, or the patient's personal representative, I am requesting a copy of the medical record held by Baptist Health.

Facility: _____

Date(s) of Service Requested: _____

_____ Summary of Medical Record
_____ Entire Medical Record
_____ Emergency Room Record
_____ Radiology
_____ Laboratory
_____ Operative/Pathology Report
_____ Immunization Records
_____ Other Information: _____

_____ Mark here if the request involves a virtual clinic visit

I understand the record may include information relating to mental healthcare, communicable diseases, and treatment of alcohol or drug abuse.

I request the record to be provided in the following format:

__ paper ___ CD ___ secure portal ___ unsecure email ___ fax (#_____)

I understand if I request the record to be provided by email that I undertake the following potential risks:

- The information may be obtained by someone else
- The information can be opened and read by someone else
- Unencrypted information does not provide any assurance of privacy or security

_____ _____
Patient Signature Date

_____ _____
Legal Representative, if not patient Date