Medical Records Request Form

By signing this form, I authorize Irish Family Practice to **REQUEST** confidential health information about me, by requesting a copy of my medical records, or a summary or narrative of my protected health information from the physician/person/facility/entity listed below.

Patient name: _____ Date of Birth: _____

The information requested is as follows:

_____

_____

_____

Initial next to each selection to also include:

_____ Mental Health Information

_____ Genetic Testing Information

_____ HIV/AIDS Information

_____ Substance Abuse Diagnosis/Treatment

Request my protected health information **FROM** the following physician/person/facility/entity:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed name Description of Personal Representative

SEND records to:
Irish Family Practice
Address: 1014 North Third St. Marquette MI 49855
Fax: 906-451-4007
Phone: 906-298-6071
Email: Info@IrishFamilyPractice.com