



Information and Instructions:

- Please complete Parts A and B on this form
- Access will be provided, unless a legal exception applies
- Prepayment of applicable fees is required prior to releasing records

PART A: REQUESTER INFORMATION

Patient Information: (If under 16 years of age, parent or legal guardian must complete form)

Last Name	First Name	Initials
Mailing Address		City/Town Postal Code
Telephone Number	Birth Date	

Parent/Legal Guardian/Executor Information:

Last Name	First Name	Initials
Mailing Address		City/Town Postal Code
Telephone Number	Relationship to Patient	

Note: Include copies of documents that provide your legal signing authority.

PART B: ACCESS REQUEST

1. Please describe what information you need and include details that will help us locate the record (e.g., dates, name of healthcare provider, etc.)

2. How would you prefer to access this information? Please check off:

- Email: _____
- Mail: please provide mailing address if different than above.

Signature	Name (Print)	Date
Witness	Name (Print)	Date