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.