**Patient Request for Protected Health Information**

Patient Name: _____ Date of Birth: _____
Name at time of Treatment (if different than above): _____
Address: _____City:_____ State: _____ Zip: _____
E-mail Address: _____ Phone:_____

**What protected health information do you want? (Check appropriate boxes below):**
Name of Physician: _____

Specific Treatment Dates:_____to_____
☐Consultation Reports ☐ Diagnostic Films ☐ Dosimetry Records ☐ Laboratory Results
☐ Physician Dictation ☐ Portal Films/Simulation Films ☐ Progress Notes
☐ Radiology or Imaging Reports ☐ Surgery/Pathology ☐ Complete Medical Record
☐ Billing Records
☐ Other (please specify): _____

**How would you like your protected health information delivered?**
☐ Paper
☐ CD/flash drive: (For paper/CD/flash drive select one): ☐ Home Delivery ☐ In-person pickup
☐ Secure Email ☐ Unsecure email* ☐ Portal ☐ Other: _____

**Information delivered through email is inherently unsecure unless it is fully encrypted. Requesting that my records are sent to an unsecured email address is not a secure delivery method and there is risk that my health information may be intercepted and/or viewed by unauthorized persons. GenesisCare USA and its affiliates, are not responsible for a third party's unauthorized access to my personal health information delivered in this format or any risks (e.g., virus) potentially introduced to my computer/device when receiving personal health information through unsecure email.*

**I request that my protected health information (PHI) from GenesisCare USA be sent to:**

☐ Self ☐ Personal Representative (indicated address below)

Recipient Name:_____
Address: _____ City: _____State: _____ Zip:_____
E-mail Address: _____ Phone: _____
Fax (healthcare provider only): _____

Patient/Authorized Representative Signature*: _____
Date:_____Time: _____

Printed Name of Authorized Representative: _____
Relationship to Patient: _____
*If signed by a patient-authorized representative, supporting legal documentation must accompany this authorization form.

Driver's License or Photo ID (*required when records are picked up*)
Driver's License State: _____Number:_____

Witness Signature: _____
Date:_____ Time:_____

**Send completed form to:**
GenesisCare USA – Health Information Management
1419 SE Terrace, Suite 200, Cape Coral, FL 33990
Attach Signed Form to: Fax: 239-344-4036 or Email: ROI@usa.genesiscare.com

**Instructions for completing the Patient-Directed Request for Health Information:**

1. Complete the first section with your current name, date of birth, current address, current e-mail address and daytime telephone number.
2. Specific treatment dates: Please list specific dates; past year or past two years. If you do not remember the specific dates please indicate at least a time frame such as last month, last six months, etc.
3. What records do you want? Mark the documents that you are requesting. Test results when marked individually are generally for specific dates of service as indicated in the next section.
4. I request my records to be sent to: Check the appropriate box. If records are being sent to someone other than the patient, then specify whom the records should be released to.
5. How would you like your records delivered? Records will be released electronically rather than on paper unless otherwise specified. Electronic format would include releasing directly to your patient portal, secure e-mail, or CD. CDs or paper records will be mailed to the address provided. Please call Health Information Management at 239-938-0121 in advance of picking up records. When picking up records in person, a photo ID will be required as well as a copy of any legal papers (power of attorney, executor of estate, proof of custody, etc.).
6. If records are going to be picked up by someone other than the patient, the name of the individual picking up the records should be listed: Please complete the name, phone number, address of the individual who will be picking up your medical records. A driver's license or photo ID will be required to be shown at the time of picking up the medical records.
7. Patient/Personal Representative Signature: This form should be signed by the patient. If the patient is unable to sign and the request is being made by an authorized personal representative of the patient (parent of a minor, person named on Power of Attorney, executor of estate, etc.), the Personal Representative should sign and date the form. Please provide printed name and relationship to the patient. Supporting legal documentation must accompany this authorization form when signed by a personal representative.
8. Witness Signature: A witness must sign and date the form in the event that the patient can only make an X or is unable to sign.

Please call GenesisCare USA Health Information Management at 239-938-0121 if you have any further questions.

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