Medical Records Request Form

By signing this form, I authorize Birchwood Family Medicine LLC 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:

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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:
Birchwood Family Medicine
Fax: 715-800-1972
Phone: 715-202-6782
Email info@birchwoodfamilymedicine.com
PO Box 2
101 West Loomis St., Suite A
Birchwood, WI 54817