GulfView Medical Institute PL
A new approach to health.

MEDICAL RECORDS REQUEST

Date: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____

Medical Records: ☐ Requesting From ☐ Releasing To

Patient / Doctor _____

Address: _____

City: _____ State: _____ Zip: _____

I request a copy of the following medical records*** for all dates of services:

Complete Medical Records
Biopsy Report(s)
Laboratory Report(s)
Other_____

***__Note:__ *If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

I release Gulf View Medical Institute PL from any laws related to the disclosure of confidential or privileged information. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Thank you for your consideration and prompt attention regarding my medical records.

_____ _____/_____/_____
Signature of Patient or Parent/Guardian/Healthcare Power of Attorney Date

_____ _____/_____/_____
Signature of Witness Date