Medical Records Request Form

By signing this form, I authorize Good Medicine DPC 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:

_____

_____

_____

Initial next to each selection to also include:

_____ Mental Health Information _____ Genetic Testing Information

_____ HIV/AIDS Information _____ Substance Abuse Diagnosis/Treatment

My health information covering the period from _____ (date) to _____ (date)

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:
Good Medicine DPC
Address: 6860 Tylersville Rd, Suite 7, Mason, OH 45040
Fax: 513-912-0784
Phone: 513-717-5412
Email: info@goodmedicinedpc.com