Patient Request for Access/Copy of Medical Records

I am a patient of Prosthetic and Orthotic Institute, Inc. and my information is listed below:

Patient Name: _____ Date of Birth: _____
Street Address: _____ City/State/Zip: _____
Telephone: _____ Email address: _____

I would like for Prosthetic and Orthotic Institute, Inc. to (choose one)

____ **Give me a copy of my health information**
____ **Send a copy of my records to or share my health information with:**

_____
Name of Facility, Person, or Company Street Address/City/State/Zip

_____
Phone Number Fax Number

_____
Email Address

I would like these dates of service to be sent/shared: _____

I want the parts of my record checked below to be sent/shared:

___ Office Notes ___ Offsite Visit Notes ___ Insurance Authorization(s)

___ Other _____

___ Entire Record ___ Itemized Bill

I want these records as a/an:

___ Email

___ Paper Copy

___ Other:

I want you to:

___ Mail them

___ Fax them to _____

___ Prepare them for pick up by _____

_____
Signature Print Name

_____
Relationship to Patient Date

-For Office Use Only-

Date records given/sent to patient: _____ ___ID Verified ___DL/OtherID _____
POI Employee Name: _____ Date: _____ # of Pages: _____

PROSTHETIC
ORTHOTIC
INSTITUTE