



Patient Request for Health Information

Patient Information (Please Print):

| | | |
|------------------------|---|---------------------------|
| <i>First Name:</i> | <i>Middle Initial:</i> | <i>Last Name:</i> |
| <i>Date of Birth:</i> | <i>Preferred Phone Number to Contact:</i> | <i>E-mail (optional):</i> |
| <i>Street Address:</i> | | |
| <i>City:</i> | <i>State:</i> | <i>Zip:</i> |

What records do you want? (Check appropriate boxes below):

Date(s) of Service: ___/___/___ through ___/___/___

- Office Notes
- Test Results (X-rays, Lab/Pathology Results) Specify: _____
- Other (Immunization Records, Medication List, Billing Records, Etc.) Specify: _____

How would you like your records delivered?

- Paper: Receive via: Mail In-Person Pick-Up
- Electronic: (Email, USB, CD, Portal) Please specify: _____

Where do you want the information sent? (Fill in boxes below):

Slocum-Dickson Medical Group, P.L.L.C. should provide my records to: Self Personal Representative

| | |
|----------------------------|----------------------------------|
| Recipient Name: | Recipient Phone: |
| Recipient Mailing Address: | Recipient Fax: |
| | Recipient Email (if applicable): |

Please print your name and sign below:

| | |
|---|--------------------------|
| Name of Patient or Personal Representative: (print) | Relationship to Patient: |
| Signature of Patient or Personal Representative: | Date: |

Please note, personal representatives must provide legal proof of representation.

Please return completed form to:

Slocum-Dickson Medical Group, P.L.L.C.
Attention: Release of Information Department
1729 Burrstone Road
New Hartford, New York 13413
Fax: (315) 798-1425

Slocum-Dickson Medical Group recognizes a patient's rights under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.