Medical Records Request Form

By signing this form, I authorize Clear Medical Clinic 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:
Clear Medical Clinic
Address:P.O Box 1887, Koloa, HI 96756
Fax: (808) 204-1876
Phone: (808) 427-2250
Email: drkrebs@clearmedicalclinic.com