Medical Records Request Form

I am requesting a copy of my medical records from your office in accordance with HIPAA and California Health & Safety Code § 123100-123149.5.

PATIENT INFORMATION

Full Name:

Date of Birth:

Address:

Phone Number: Email Address:

Medical Record Number (if applicable):

HEALTHCARE PROVIDER INFORMATION

Healthcare Provider's Name:

Address:

Program:

I REQUEST THE FOLLOWING RECORDS (CHECK ALL THAT APPLY):

For the date range: To:

Treatment records	Test results	Diagnoses
Prescriptions	Consultation notes	Mental health records (excluding psychotherapy notes)

Other (specify):

Format:	Paper copy	Electronic Copy
Delivery Method:	Mail to the address provided above	Send via encrypted email

Authorization

If you require any additional authorization forms or documents, please contact me using the information provided above.

Patient Signature:

Date:

For Office Use Only

Date Request Received:

Date Processed:

Processed By:

Email all requests to compliance@buckelew.org or send via mail to 201 Alameda Del Prado, Suite 103, Novato CA 94949 Attention: Q&C Department. All requests will be handled within 15 days from receipt.