

**A** **l** **a** **R** **a** **O** **b** **a** **P** **i** **c** **d** **H** **a** **I** **l** **a** **(PHI)**

\_\_\_\_\_  
RELEASE copies of your record to (or discuss your information with) the provider/person/facility below

OBTAIN copies of your record from (or discuss your information with) the provider/person/facility below

\_\_\_\_\_  
Name of Provider/Person/Facility

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone # / Fax # (include area code)

**HEALTH INFORMATION**

Chart Note(s)  
Laboratory Results  
X-Ray Report/CD  
Immunization Records

Pharmacy Records  
Itemized Billing Statement(s)  
Other

