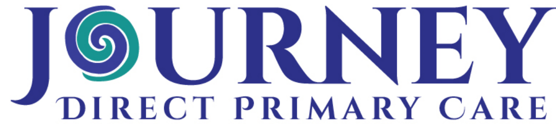

Medical Records Request Form

By signing this form, I authorize Journey Direct Primary Care 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:
Journey Direct Primary Care
Address: 2341 John Hawkins Pkwy, Suite 133, Hoover, AL 35244
Fax: 205-832-6602
Phone: 205- 557-4450
Email: drshugrue@journeydpc.com