The HSC Pediatric Center
Patient Request for Health Information

Patient Information (Please complete the form)

First Name:	**Middle Initial:**	**Last Name:**	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	**Phone:**	**E-mail (optional):**	
Street Address:	**City:**	**State:**	**Zip Code:**

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

Date(s) of Service: _____/_____/____ through ____/____/____

___ Discharge Summary **____ History & Physical** **____ Complete Medical Record** **____ Billing Record**

___ Outpatient Therapy Record **____ Progress Note** **____ Immunization Record**

___ Test Results (X-ray, Lab) Please Specify: _____ **____ Other Please Specify _____**

**** If the medical record contains any of the following sensitive information, HSC Pediatric Center will only release these records if your initials are next to the type of information listed below.***

_____ Drug and/or alcohol treatment or testing **_____HIV information**

_____ Mental/Behavioral health information (a separate release is required for notes taken during psychotherapy sessions).

How would you like your records delivered? (Check appropriate item below):

_____ Paper (Choose one) **_____ Home Delivery** **_____ In-Person Pickup**

_____ Electronic (Choose one) **_____ CD** **_____ Email** **_____ Fax**

Where do you want the information sent?

The HSC Pediatric Center should provide requested information to: _____ Self _____ Other Representative (indicated below)

Recipient Name:	**Recipient Phone:** **Recipient Fax:**
Recipient Mailing Address:	**Recipient E-mail (if applicable):**

I give authorization/permission for The HSC Pediatric Center to release, use and/or share the medical information described above. I understand that this permission is voluntary. I also understand that once this information is released, used and/or shared, the person or organization that received it may share it again. If this happens, the information may no longer be protected under applicable privacy laws. The HSC Pediatric Center recognizes a patient's right under HIPAA to access copies of his/her health information. **This authorization is valid for 6 months from date signed.** There may be charges associated with processing a request and producing requested records.

_____ _____

Name of Patient or Representative (please print) **Relationship (please print)**

_____ _____

Signature of Patient or Representative **Date**

Please return completed form to: HIM Department of The HSC Pediatric Center 1731 Bunker Hill Road NE Washington, DC 20017

Fax: (202) 635 5786 **Email: recordrequest@hschealth.org** **Questions? Call (202) 635 6141**