Patient Request for Health Information Form

Our Healing Roots, LLC recognizes a patient's right of access under HIPAA. There may be charges associated with processing a request and producing requested records.

Patient Information (Please Print)

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:

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

Date(s) of Service:____/____/____through____/____/____

☐ Chart Notes ☐ Laboratory Results ☐ Documents ☐ Billing Records

☐ Genetic Results—Please specify: _____

☐ Other, Please specify: _____

How would you like your records delivered?

☐ Paper

☐ Mail Delivery

☐ In-Person Pickup

☐ Electronic (Email, USB, CD, Portal, Other) Please specify: _____

Where do you want the information sent? (Fill in boxes below):

Our Healing Roots, LLC should provide my records to: ☐ Self ☐ Personal Representative (indicated below)

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

Please print your name and sign below:

Name of Patient or Personal Representative (please print)	**Relationship to Patient (please print)**
Signature of Patient or Personal Representative	**Date/Time**

Please return completed form to:

Our Healing Roots, LLC
760 Short State Hwy. P
Seymour, MO 65746

E-mail: office@ourhealingroots.net
Fax: 1-844-685-0298

IMPORTANT! Please call 417-319-3081 if you don't get a confirmation of receipt in 72 hours.

For internal use by *Our Healing Roots, LLC* only:

Patient Identification #:	***Date Received:***	***Date Processed:***	***Processed By:***
Fee Charged:	***Were Records Reviewed On-site?***	***Date Reviewed:***	