Request for Medical Records

_____ *Name of Health Care Provider or Hospital Medical Records Dept.* _____ *Address of Provider* _____ *City, State and Zip*	RE: _____ *Your Name* _____ *Your Date of Birth* _____ *Your Health Plan Number* _____ *Your Phone Number*

To whom it may concern: _____
Today's Date

Please fax a copy of my medical records covering the previous 12 MONTH only to:

Dr. Tishler c/o Inhale MD Medical Consulting
1035 Cambridge St. Ste 17B
Cambridge MA 02141
FAX 617.477.8886 Phone 617.477.8886

The purpose of this disclosure is provision of medical care.

Please include:

1. Current problem list, abstract, and summary of major medical issues, with specific emphasis on the conditions checked below:

☐ Chronic pain (of at least 6 months duration)	☐ ALS (Lou Gehrig's disease)
☐ Severe nausea	☐ Multiple Sclerosis
☐ Seizures	☐ Rheumatoid Arthritis
☐ Severe muscle spasms	☐ Alzheimer's or other Dementia
☐ Wasting syndromes	☐ PTSD
☐ Cancer	☐ Chronic Anxiety
☐ Glaucoma	☐ Crohn's disease
☐ HIV or AIDS	☐ Chronic Insomnia
☐ Hepatitis C	☐ Other debilitating illnesses: _____ _____

2. Current medication list and drug allergies.

3. Laboratory or written radiology results associated with the current problem list.

4. Prior two visits for condition(s) checked above.

5. I give specific permission to release any information of the nature below, UNLESS I have initialed each type:

__ SUBSTANCE ABUSE
__ PSYCHIATRIC/MENTAL HEALTH INFORMATION
__ HIV/AIDS INFORMATION

This authorization will expire sixty (60) days from the date signed. I understand that I make revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance thereon. I understand that if I am releasing this information to an entity or individual not covered by HIPAA, this information is no longer protected by HIPAA. Medical care will not be conditioned upon signing this document except to the extent that signing and obtaining records may be necessary to provide such care.

Patient's or Legal Guardian's Signature _____

A patient is entitled to this information per HIPAA privacy rule it allows your office 30 days to provide the records and doctors may not hold medical records because the patient has not paid for services provided. You may charge a reasonable fee for the cost of copying and mailing records – but this request is for a fax of the records only.