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* *Your Home Zipcode*

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 Health & Wellness

2285 Massachusetts Ave. Ste 102

Cambridge MA 02140

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.
2. Current medication list and drug allergies.
3. Laboratory or written radiology results associated with the current problem list.
4. 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.