REQUEST FOR RECORDS

Patient Name: _____ **Date of Birth:** _____

Address: _____

Phone Number: _____ Medical Record Number: _____

PROVIDE RECORDS FROM THE FOLLOWING:

☐ TMC Hospital/Rincon Hospital ☐ TMC One ☐ Hospital Outpatient Clinic: Pain/Wound/Sleep/ Outpatient Therapies ☐ TMC Cancer Center

HISTORICAL RECORDS FROM TMC HEALTH FACILITY: ☐ El Dorado Hospital ☐ Palo Verde Hospital ☐ Copperstate OBGYN ☐ TMCOne Obstetrics ☐ Pulmonary Associates ☐ Northwest Neuro ☐ APSU

SPECIFIC INFORMATION TO BE RELEASED:

Dates of service: ☐ From _____ to _____ OR ☐ All dates of service (last 2 years unless otherwise specified)

☐ Pertinent Information (H&P, Discharge Summary, Consults, ED Provide notes, EKG, Labs, and Radiology reports)

☐ Provider Notes ☐ Discharge Summary ☐ Operative Report ☐ Emergency Department Notes ☐ Billing Records

☐ History & Physical Exam ☐ Lab Results ☐ Imaging Reports ☐ Imaging films on CD

☐ All Records (last 2 years unless otherwise specified) ☐ Other: _____

I authorize the provider to disclose information pertaining to: (check all that apply)

☐ Mental Health ☐ Alcohol and/or Drug Abuse ☐ Communicable Diseases, including HIV/AIDS

Purpose of Request: ☐ At the request of the patient ☐ Continuity of Care ☐ Other: _____

Release Information To: ☐ Patient (Self) ☐ Other (3rd Party): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Form and Format: (Check Preference) ☐ Paper ☐ CD ☐ USB Drive ☐ Fax ☐ Email ☐ MyChart Portal

☐ Call to Pick Up: _____

☐ Mail to: _____

☐ Email: _____ ☐ Encrypted ☐ Unencrypted*

***By electing to receive the requested records via unencrypted email, I acknowledge selection of an unsecured transmission method, and I release TMC Health from all responsibility related to the potential interception, unauthorized disclosure, and/or unauthorized use of the transmitted information. Initials:** _____

Completion of this Request for Records form does not guarantee approval of your request. TMC Health will review the record request and will respond either by providing the requested records in the form and format indicated or by providing an explanation of denial within thirty (30) days from receipt of this request. By signing below, I acknowledge that reasonable costs may apply to the labor, supply, and postage associated with providing the requested records per applicable Federal and State regulations. I also acknowledge that completion of this Request for Records does not constitute a HIPAA authorization.

PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE **PRINTED NAME/RELATION TO PATIENT** **DATE** **TIME**

TMC Health – Health Information Management Department
Address: 5301 E Grant Road, Tucson, AZ 85712 **Phone:** (520)324-5166 **Fax:** (520)324-1590
Email: tmc.medicalrecordsrequest@tmcaz.com **Website:** tmcaz.com/medical-records

Check List Verified
Date:
Initials:

TMC HEALTH

Request for Records
Authorization to Release Protected Health Information