TEAM MOBILE HEALTH CARE

Our Team is Your Team

MEDICAL RECORD REQUEST FORM

Request for Copies of Protected Health Information

(In compliance with HIPAA)

1. PATIENT INFORMATION

Patient Name:		**Date of Birth:**	
Address:		**Phone Number:**	
City, State, ZIP:		**Email (Optional):**	
Patient / Legal Representative:		**Relationship to Patient:**	

If you are not the patient, proof of legal authority may be required (e.g., Power of Attorney, Guardianship Documentation).

2. RECORDS REQUESTED

Please check all that apply:

- ☐ Patient Care Report (PCR)
- ☐ Face Sheet
- ☐ Medication Administration Record
- ☐ Billing Records
- ☐ ECG / Monitor Strips
- ☐ Other: _____

Date(s) of Service: From: _____ To: _____ **Specific Information Requested** *(if applicable)*: _____

3. IDENTITY VERIFICATION

A copy of a valid government-issued photo ID **must** accompany this request.

If this request is submitted by a legal representative, documentation establishing legal authority (such as a Power of Attorney, Guardianship Order, or other applicable legal documentation) **must** also be provided.

- ☐ Government-issued photo ID attached
- ☐ Legal authority documentation attached (if applicable)

4. REQUESTER SIGNATURE

By signing below, I am requesting copies of the medical records identified above from Team Mobile Health Care.

SIGN

_____ _____

Patient / Legal Representative Signature — Date Signed (mm/dd/yyyy)

_____ _____

Printed Name — Relationship to Patient (if not patient)

5. FOR OFFICE USE ONLY

Date Received: _____ Processed By: _____

Date Completed: _____

Method of Delivery:

☐ Mail ☐ Fax ☐ Email ☐ Other _____

Fax: (404) 635-2393

Notes: _____

6. VERIFICATION / CONFIRMATION

Information requested above has been prepared in accordance with state and federal regulations.

_____ _____

Authorized TMHC Representative Signature — Date

7. HIPAA NOTICE

This information has been disclosed to you from records whose confidentiality is protected by federal law (HIPAA). The federal regulations prohibit you from making any further disclosure of this information without the **specific written consent** of the person to whom it pertains or as otherwise permitted by law.

POLICY REMINDER

- All released information must comply with HIPAA regulations.
- Only the minimum necessary information should be released.
- Retain this request in the patient record in accordance with TMHC policy.

Our Team is Your Team.

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