Patient Medical Record Request

Phone: 501.320.1681 Fax: 501.604.8799 Email: recordsrequest@lrdc.com

Please complete this form to receive your medical records in electronic PDF files or printed copies.

Recipient Name			**Phone (Required for Pick Up)**
Street Address			
	Street	**Suite / Apt #**	
	City	**State**	**Zip**

Choose Only One: **Email Delivery** ☐ **Paper Delivery** ☐ **Pickup At Clinic** ☐

Email Address for Record Delivery

Patient Name			
	First	**Last**	**Date of Birth**
Records Requested/Date Range Needed			

Please provide me with the medical records described above, via designated delivery method.

****If requested **electronic/email delivery**, I understand and agree that:

- I must provide a valid email address, either my own or that of my designated recipient.
- My records will be provided as Adobe PDF files on CIOX Health's **eDelivery** website.
- I will receive an email from **cioxhealth.com** containing instructions for accessing my records.
- My **4-Digit PIN** to access the PDF file containing my records will be my **Year of Birth**.

Requester Signature _____ Date**:** _____