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	
Street Address			
	Street	Suite / Apt #	
	City	State	Zip

☐ **Electronic Delivery** ☐ **Paper Delivery** ☐ **Pickup (Phone # Required)**

Email Address for record delivery

☐ **Medical Records** Requested ☐ **Billing Records** Requested

Patient Name			
	First	MI	Last
Date of Birth			
Date of Service			
	From	To	

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

If requested electronic 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.

Requester Signature _____ Date**:** _____