Vector Health

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936-202-3126 (f)

Medical Records Request

Patients or their legal representatives may use this to transfer records to and from this facility.

We take privacy very seriously, and may request verification of identity/guardianship.

Full name for which records are requested: ______________________________

Birthdate: ____________ Address: ______________________________

Phone: ______________ Email: ______________________________

Name of requestor, if different from above: ______________________________

○ **Request entire record**

Request reports related only to:

○ Laboratory	○ EEG	○ Medications
○ Radiology	○ Clinician/office visits	○ Allergies
○ Pathology	○ Consultations	○ Inpatient Admissions/Discharges
○ EKG	○ Procedures	○ Other______________________

Date limitations, if desired: __________________ to ___________________

Records to be ○ **sent in to us from** / ○ **transferred out from us to** the following facilities/healthcare providers/other:

Provider/Facility Name: ______________________________

Phone:______________________________ Fax: ______________________________

Address/General Location: ______________________________

Specialty/Affiliation: ______________________________

If you change your mind about records release, just call us; we honor this, if we've not already sent/got them.

This authorization is ineffective 180 days from the date signed, or (if less) by the date indicated here: ____________.

Be aware that if the person/entity that gets your records is not a provider or plan covered by federal privacy regulations, the records could be shared again without consent, as they are no longer protected by those regulations.

Records released for transfer may contain potentially sensitive information about you, such as HIV/AIDS, sexually transmitted diseases, substance abuse issues, behavioral health concerns, or other chronic health conditions.

Vector Health will not take money, nor change our attitudes about your care because you complete this form.

Signature: ______________________________ Date:____________________

Printed name: ______________________________ Relationship to Patient: ____________________

Minor's Signature (if applicable):______________________________ Date: ____________________

(Required for the release of certain kinds of information such as reproductive care, sexually transmitted diseases, substance misuse, behavioral health, in accordance with Texas Family Code 32.003)