CRAIG
3425 S. Clarkson St.
Englewood, CO 80113
303-789-8232

Patient Request to Access Medical Records Form

MRN: _____
Release ID: _____

Patient's Full Name:					
Street Address:					
City:		State:		Zip Code:	
Email Address:					
Phone #:		**Date of Birth:**			
Last 4 of Social Security #:		Driver's License/State Issued ID #:			

1. I am requesting access to/copies of the following:	2. I would like to receive my medical records as follows:	3. Purpose for Medical Records Request:
☐ Medical Records ☐ Radiology Images ☐ Other: _____	☐ *Mail ☐ Send OneDrive link via email ☐ *Personal Pick Up ☐ Fax ☐ **Radiology Images (select one)** ◯ Imaging link via email ◯ USB *Paper Records or USB dependent on volume	☐ Personal Records (Self) ☐ Continuation of Care (PCP, Hospital, etc.) ☐ Insurance Claim ☐ Attorney
☐ Send to (Doctor, Hospital, Insurance, Attorney, Self)	Name: Address: Phone: / Fax: Email:	

Dates of Service/Treatment Requested:	_____ to _____ **MM/DD/YY** **MM/DD/YY**
Select information you are requesting:	☐ Labs ☐ History & Physical ☐ Discharge Summary ☐ Urology ☐ Radiology Reports ☐ Outpatient Records ☐ Psychology ☐ Team Conferences ☐ **Entire Record** ☐ Other: _____ ☐ PT/OT/ST Initial & Discharge Evaluations _____

I certify that this request to access health information is made voluntarily and that the information given above is accurate to the best of my knowledge.

Signature of Patient/*Legal Representative: _____ Date: _____

Print Name/Relationship: _____ Date: _____

*Note: If legal representative, provide a copy of the documentation that establishes you as the legal representative.