How to Request a Copy of Your Medical Records

Step 1: Fill Out the Form

To request a copy of your medical records for yourself or to have your medical records sent to a doctor's office or other third-party, complete the Authorization to Disclose Health Information form below.

All fields on the form must be completed and signed by you or your designated representative and clearly state the dates of service, the specific type of record(s) desired, and the reason for the request. If your designated representative is signing for you, please indicate why under the signature line.

You can also ask for copies of this form to be mailed, e-mailed or faxed to you.

Step 2: Submit the Form

Once completed, please use one of the following methods of communication to submit the form back to us. As soon as we receive your completed form, we can begin processing your request:

Fax: 800-355-1029

Mail: Pentec Health Inc.
4 Creek Parkway
Boothwyn, PA 19061
ATTN: Compliance Department

Email: Compliance@pentechealth.com

Costs for Copies

In accordance with federal and state laws, processing fees and copying charges may apply.

If the record is being released directly to you, your physician or another health care facility, there is no charge associated with copying your records.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I, _____ hereby authorize Pentec Health, Inc. ("Pentec") to release
(Patient Name)
my health information described below ("Information") to: _____;
(Recipient Name)
at _____; _____.
(Recipient Address) (Recipient Phone)

The Information that may be disclosed is:

- ☐ Records dated _____ to _____
- ☐ AIDS/HIV information
- ☐ Mental Health
- ☐ Other: _____

The purpose of the disclosure is (explain or indicate "at the request of the individual"):

_____

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") and various state laws govern the terms of this Authorization. I understand this Authorization is limited to the Information stated above. Prior to disclosing psychotherapy notes or genetic, mental health or substance abuse information that is specially protected under state law, a separate written authorization will be obtained.

I understand that I may revoke this Authorization at any time. My revocation must be in writing and must include my name, address, telephone number, date of this Authorization and my signature, and I should send it to: Pentec Health, Inc., 4 Creek Parkway, Boothwyn, PA 19061, Attn: Privacy Officer. My revocation will be effective upon Pentec's receipt of such revocation, but will not be effective to the extent that Pentec or others have acted in reliance upon my prior Authorization.

I understand that Pentec may not condition treatment on my signing of this Authorization.
I understand that any Information disclosed pursuant to this Authorization may be subject to re-disclosure by the above named recipient, and therefore no longer protected by HIPAA.

This Authorization shall expire on the _____ day of _____, _____.*
(Date) (Month) (Year)

(*If no expiration date is provided, this Authorization shall expire one year from the Date of Signature listed below.)

I understand that I have a right to receive a copy of this Authorization by contacting Pentec in the manner described above.

_____ _____
Signature of Patient or Personal Representative* Date of Signature

_____
Address of Patient

_____
*Description of Personal Representative's Authority (must also submit copies of legal documents supporting this authority)