



## Medical Records Request Form

By signing this form, I authorize SOLYMAR Direct Health to **REQUEST** confidential health information about me, by requesting a copy of my medical records, or a summary or narrative of my protected health information from the physician/person/facility/entity listed below.

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

The information requested is as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Initial next to each selection to also include:

\_\_\_\_\_ Mental Health Information                      \_\_\_\_\_ Genetic Testing Information  
\_\_\_\_\_ HIV/AIDS Information                              \_\_\_\_\_ Substance Abuse Diagnosis/Treatment

My health information covering the period from \_\_\_\_\_ (date) to \_\_\_\_\_ (date)

Request my protected health information **FROM** the following physician/person/facility/entity:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Description of Personal Representative

**SEND** records to:

**SOLYMAR Direct Health**

Address: 300 Jefferson Blvd, Suite 103, Warwick, RI 02888

Fax: 401-560-2651

Phone: 401-388-4256

Email: [info@solymardirecthealth.com](mailto:info@solymardirecthealth.com)