



## Medical Records Request Form

By signing this form, I authorize Crossroads Integrative Medicine 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:

**Crossroads Integrative Medicine**

Address: 11 Municipal Drive STE 200 Fishers, IN 46038

Fax: 317.548.8483

Phone: 317.426.7557

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