ARIZONA BLOOD & CANCER SPECIALISTS

A Partner of OneOncology

Patient Request for Access/Copy of Medical Record

Note: Patients requesting a copy of their Medical Record must submit this completed form.

Patient Information

Name (First, Middle, Last)	
Address Line 1	
Address Line 2	
Phone (Home)	
Phone (Mobile)	
Date of Birth	
Social Security Number	
Patient Record Number (if known)	

Records Requested From:

Organization Name	
Address Line 1	
Address Line 2	
Phone	
Fax	

I hereby request a copy of my medical record and request that my record be delivered to the following organization and at the address below (and contact information if the address is not my home address):

Arizona Blood & Cancer Specialists, ATTN:	
Address Line 1	
Address Line 2	
Phone	
Fax	

I request a copy of my medical record in the following format:

Paper	
Encrypted email	
Encrypted USB	
Encrypted DVD	

I understand that my medical record will be provided in a paper copy unless another format is requested by me.

I also understand that if I request an electronic copy, delivered either by mail or electronically, then the copy will be provided in an encrypted format with the decryption key delivered separately.

If I refuse encryption of my electronic information, I understand that my electronic record will not be secure and I hereby release and forever waive any claims that may arise or that I may have had at any time with regard to an unsecure copy of my electronic health record or unsecure delivery of my electronic health record and that in the event of a breach of such electronic health record, Arizona Blood & Cancer Specialists is released from any obligations or liability arising under any federal or state law.

_____

(Date)

_____

(Signature of Individual or Patient Representative)

If signed by a Personal Representative, please complete the information below:

If you are signing as a Power of Attorney, Legal guardian, Executor, or Administrator, attach a copy of the legal documents. You do **NOT** have to attach copies of these documents if they are already on file with Arizona Blood & Cancer Specialists.

Personal Representative's Name	**Relationship to Individual**
Personal Representative's Address	**City, State, ZIP**
Personal Representative's Telephone Number	**Personal Representative's E-mail address (optional)**