Medical Records Request Form

Records requests may be submitted in person, by mail, or electronically. A copy of your government-issued photo identification must be included with your request to verify identity prior to release of protected health information.

Section 1 – Client Information

Full Legal Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Address: _____ City/State/Zip: _____

Section 2 – Description Of Records Requested

Please describe the specific records requested (check all that apply):

☐ Complete Medical Record

☐ Treatment Notes

☐ Procedure Reports

☐ Lab Results

☐ Billing Records

☐ Photographs

☐ Other (specify): _____

Date Range of Records Requested (if applicable): _____

Section 3 – Format & Delivery Method

Preferred Format (select one):

☐ Electronic (secure email or portal)

☐ Email to: _____

☐ Paper Copies

☐ Mail to address listed above

☐ Other: _____

Section 4 – Authorization To Release To Third Party (If Applicable)

I authorize Angell Medical Spa to release my records to:

Recipient/Organization Name: _____

Phone: _____ Email: _____

Address: _____ City/State/Zip: _____

Section 5 – Client Acknowledgments

• I understand I have the right to inspect and obtain a copy of my protected health information under federal law (45 CFR §164.524) and California Health & Safety Code §123110.
• I understand that identity verification is required before records are released.
• I understand that records will be provided within 15 days as required by California law, unless an extension is legally permitted.
• I understand that reasonable, cost-based fees may apply for copying and mailing in accordance with applicable law.
• I understand that certain limited information may be withheld if permitted by law (e.g., psychotherapy notes or if disclosure could endanger safety).

Signature of Client or Legal Representative: _____

Printed Name: _____ Date: _____

If signed by Legal Representative, relationship and authority (attach documentation):

_____

For Office Use Only

Identity Verified By: _____ Date: _____

Date Request Received: _____

Deadline for Response: _____

Date Completed: _____

Fees Charged (if any): _____

Method of Delivery: _____