RELEASE OF MEDICAL RECORD REQUEST

Your medical provider(s) value your privacy and have contracted with PROVIDER1ST (Subsidiary of Advantmed) to process all requests for Release of Information (ROI). PROVIDER1ST provides secure and efficient ROI services so that you can rest assured your records are only released following strict HIPAA guidelines.

Requests for release of information must be made in writing and signed by the patient or their legally authorized representative.

To request your medical records you may mail or fax a completed authorization form back to us. We have attached the authorization form for your convenience.

ELECTRONIC RECORD DELIVERY Q&A

Q: Why is my email address needed?

A: This is how you will be notified when your records are ready and how to access them.

Q: Can I provide the email address of someone other than myself?

A: Yes.

Q: How will I access the records?

A: You will receive an email from PROVIDER1ST.com containing instructions for accessing the records.

Q: How long will I have to view the records?

A: You will have 30 days from when you receive email notification that the records are ready.

Q: What format will the records be in?

A: Adobe PDF Files.

Q: Can I print or download the records from the website?

A: Yes.

FAX

Fax to:
(800) 818-2114

MAIL

Mail To:
P.O.BOX 54650
Irvine, CA 92619

@

Email to:
requests@provider1st.com

Questions call us:
(855) 514-2378

Provider 1ST

PATIENT REQUEST FOR MEDICAL RECORDS

Patient Name (please print clearly):____

Release Records from (Name of Doctor or Practice):______________________________________

Doctor or Practice Address:____

Purpose of the recordS:____

Date of Birth:____

Address:______________________________ City:__________ State: __________

Zip code:____________________ Phone Number: ______________________________

Email Address (required for electronic delivery option): ______________________________

Information requested-Check all that applies:

☐ All health care information in my record (including immunizations, lab/pathology, and radiology reports)

☐ Immunization records only

☐ Lab/Pathology results only-date(s) or type(s):

☐ Radiology images only - date(s) or Type(s):

☐ Specific information only:

Delivery Options:

☐ I would like the records mailed to the above address.

☐ I would like electronic delivery of the records

_ _

Patient or legally authorized representative signature **Date**

_ _

Relationship to patient **Printed name if signed on behalf of patient**

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