

## Electronic Record Delivery Request

Complete this form, along with a HIPAA Authorization, to receive your medical records as electronic PDF files rather than as printed copies

Requester Name					
	First		Last		
Street Address					
	Street		Suite / Apt #		
	City		State	Zip	
Email Address for record delivery					
Medical Records Requested					
Patient Name					
	First		MI	Last	
Date of Birth					
Date of Service					
	From		То		
_	vide me with the medical records described above	e through	the HealthPort el	Delivery online service.	

I understand and agree that:

- I must provide a valid email address, either my own or that of my designated recipient.
- My records will be provided as Adobe PDF files on HealthPort's eDelivery website.
- I will receive an email from **HealthPort.com** containing instructions for accessing my records.
- If I do not retrieve my records within 30 days, they will be deleted.
- There may be a fee for collecting my records. If so, an invoice will be included with the records.

Signature	Date:
· ·	<del>-</del>