PATIENT ACCESS REQUEST FOR HEALTH INFORMATION FORM

TrueCare recognizes a patient's right of access under HIPAA and the 21st Century Cures Act Information Blocking Rules.
I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: TrueCare, 400 S. Melrose Drive, Suite 200, Vista, CA 92081. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

First Name:	Middle Initial:	Last Name	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	Email:	
Street Address:	City:	State:	Zip:

What record(s) are you requesting? (Check appropriate boxes below):

Date(s) of Service:___/___/___through___/___/___ **If no date is specified, only previous 6 months will be released.**

☐ Visit Notes ☐ Dental Notes ☐ Procedure Reports ☐ Billing Records

☐ Test Results (Please Specify):_____(X-Rays, Lab/Pathology Results, Mammogram, Colonoscopy, DEXA, Pap Smear)

☐ Other (Please Specify):_____(Immunization Records, Medication Lists, Mental Health, HIV Test Results)

How would you like your records delivered (please select one of the options below)?

☐ Paper/Mail Delivery ☐ TrueCare Location:_____ ☐ Third Party App: _____

☐ Send my records via (please circle desired option): CD/DVD, USB

☐ Electronic (please circle desired option): Secure Email (email address)_____,
MyChart messaging application, if other please specify: _____

Purpose of Request: ☐ Continuity of Care/Specialty Care ☐ Primary Care Provider Change

☐ Legal ☐ Other: _____

Where do you want this information sent? (Fill in boxes below):

TrueCare should provide my records to (indicated below): ☐ Self ☐ Personal or Legal Representative

☐ TrueCare provider to verbally communicate my health information with:

Recipient Name:	Recipient Phone: Recipient FAX:
Recipient Address:	Recipient Email (if applicable):

Please Print your name and sign below:

Name of Patient or Personal Representative (Please Print)	**Relationship to Patient (Please Print)**
Signature of Patient or Personal/Legal Representative, **Date** This request will expire 1 year from signed date unless otherwise specified.	**Phone Number**

Please return completed form to: TrueCare Health Information Department

TrueCare 400 S. Melrose Drive, Suite 200 Vista, CA 92081	Email: FAX_HID@truecare.org Fax:1-877-279-1995
	Question? 760-736-6717

For internal use by *TrueCare* only:

Patient Medical Record #:	Date received:	Were records given on-site?	TrueCare Location:
Date processed (in-clinic/HID):	Processed by:		