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, 4056 Calle Platino, Oceanside, CA 92065. 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 4056 Calle Platino Oceanside CA 92056	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:		