WESTFIELD PREMIER PHYSICIANS | Direct Primary Care
Family & Internal Medicine

# Medical Records Request Form

By signing this form, I authorize Westfield Premier Physicians to **REQUEST** confidential health information about me, by requesting a copy of my medical records, or a summary or narrative of my protected health information from the physician/person/facility/entity listed below.

Patient name: _____ Date of Birth: _____

The information requested is as follows:

_____

_____

_____

Initial next to each selection to also include:

_____ Mental Health Information

_____ Genetic Testing Information

_____ HIV/AIDS Information

_____ Substance Abuse Diagnosis/Treatment

Request my protected health information **FROM** the following physician/person/facility/entity:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed name Description of Personal Representative

**SEND** records to:

**Westfield Premier Physicians**
**Fax: 317-896-1299**
Phone: 317-763-2131
info@westfieldpremier.com
15229 Westfield Blvd
Carmel, IN 46032