Medical Records Request Form

This is a request to receive a copy, summary, or narrative of medical records for:

First Name	Last Name	MI	Date of Birth	Last 4 SSN
Street Address	**City**	**State**	**Zip Code**	
Email Address:		**Telephone**		

(Please select the following entity you would like to request records from:

☐ Full Spectrum Emergency Room at the Rim

☐ Full Spectrum Emergency Room at Hardy Oak

☐ Full Spectrum Urgent Care at the Rim

☐ Full Spectrum Urgent Care at Hardy Oak

RECORDS TO BE RELEASED FROM: **Spectrum Healthcare and all covered entities.**

Please provide the dates of service you are requesting below:

Record(s) of care from the following dates of service. If multiple please list each date below

_____ _____ _____

_____ _____ _____

Select one of the following options for processing your request:

☐ **Option 1: Records will be printed and available for pickup in our facility within 14 business days (A valid government-issued ID will be required for verification).**

☐ **Option 2: We will mail the requested documents via certified mail to the address you provide for a $40.00 per visit fee.**

Mail to: _____

Email is NOT an option as there is no way to ensure HIPAA-compliant transmission of documents.
Optional: To prevent any delay please attach a copy of all corresponding court documents

☐ **Continued Care**	☐ **Referral to a Specialist**	☐ **Change of Doctor/ Provider**	☐ **Personal**
☐ **Insurance**	☐ **Workers Comp**	☐ **Disability Determination**	☐ **Legal**

I understand that this request will be processed within 14 business days from receipt and that a fee for preparing and furnishing this information may be charged according to rulings set forth by The Texas Legislation.

Requestor's Name: _____ Relationship to Patient: _____

Signature of Requesting Party: _____ Date: ___/___/_____

Return Completed Forms to: Spectrum Healthcare at patientrequests@spechealth.com

18007 IH 10 W
San Antonio, TX 78257