Request for Patient Medical Records

Form Submission Instructions

Please submit the completed form (and proof of representation, if required), to the mailing, fax, or email address listed at the bottom of the page, **ATTN: Patient Records.**

Patient Information

First Name (Required)	Middle Name or Initial (Required)	Last Name (Required)
Other Names (Nicknames, Alternative Spellings, Maiden Names) (Required)		Date of Birth (Required)
Current Address (Required)		Social Security Number (Last Four Digits) (required)
E-Mail Address	Phone Number	Insurance Provider Name

Medical Record Information

Name of Ordering Physician or Practice (Required)	Address of Ordering Physician or Practice (Required)	Approximate Dates of Service (MM/YY) (Required)	Phone Number or E-Mail Contact Information

Medical Records Requested

Laboratory Test Results ☐ Laboratory Testing Order Forms ☐ Billing Records ☐ All Records ☐

Patient Authorization

By my signature, I authorize DrugScan to identify all medical records specified above and provide me or my designee with copies of those records to the recipient and location specified below. NOTE: If you are a legal representative of the patient, please provide proof of representation with this form (see form instructions for examples of appropriate documentation).

	☐ Self	☐ Parent	☐ Legal Guardian	☐ Legal Representative
Printed Name **(Required)**	Relationship **(Required)**			
Signature **(Required)**	Date **(Required)**			

Delivery Instructions

Recipient Name	Address (if different than listed above), Fax Number, or E-Mail Address	☐ Mailed Documents ☐ Imaged Documents ☐ Faxed Documents
Recipient Name	Address (if different than listed above), Fax Number, or E-Mail Address	☐ Mailed Documents ☐ Imaged Documents ☐ Faxed Documents
Recipient Name	Address (if different than listed above), Fax Number, or E-Mail Address	☐ Mailed Documents ☐ Imaged Documents ☐ Faxed Documents

Questions call Customer Service at 800-235-4890
DrugScan will respond within 30 days of receipt of completed request

PO Box 347, Horsham, PA 19044 Fax: (888) 488-8874 Email: CustomerService@drugscan.com

Request for Patient Medical Records

Patients and/or their legal representatives are entitled to receive medical records upon request based on information provided by the requestor. The Request for Patient Medical Records form includes all of the required information and additional information that can be helpful in locating and authenticating documents associated with the patient. All required information must be completed for any record search to occur; requestors are encouraged to provide us with additional information whenever possible as well. Before completing the form, please review it in its entirety and contact our Customer Service Department with any questions prior to submitting the request. Required fields are highlighted in yellow; failure to provide required information may result in requests not being processed.

Patient Information

This includes the patient's name (including any others that could be associated with his or her medical records), a current address, the last four digits of the patient's social security number, additional contact information, and the name of the insurance company associated with any billing records requested.

Medical Record Information

This includes the name(s) of ordering physician(s) or practice(s) associated with the medical records requested. Addresses and approximate dates of service are also required. Providing a contact number or e-mail address allows us to further research patient records if additional information is needed to authenticate them.

Medical Records Requested

Laboratory test results and testing order forms are provided without interpretation. If clarification regarding the reason that testing was performed or what the test results mean is desired, please discuss this with the ordering physician. Billing invoices can be requested at any time without using this form; simply contact our Billing Department at 800-235-4890 and request that copies be sent. They are listed on this form so that they can be included with other requested records. Please note that medical records will be provided for any date range specified up to the date that this form is signed. Requests for future records must be submitted separately.

Patient Authorization

The requestor must sign and date the form. Please print the name legibly. The relationship to the patient must also be selected. If the requestor is the patient, then no additional documentation is required. Emancipated minors must provide legal proof of this status and parents need to submit a birth certificate for the patient or a legal document listing the requestor as the parent or step-parent of the patient. For a requestor designated as a legal representative, proof of that relationship must be submitted with the form. Standard forms of legal representation include, but are not limited to, Power of Attorney and documentation of legal guardianship. Please contact the Customer Service Department at 800-235-4890 or CustomerService@drugscan.com with any questions regarding required documentation. If sufficient documentation is not provided to authenticate the right of a requestor to have access to a patient's medical records, the requestor will be contacted and advised that the record search cannot be initiated until the appropriate documentation is received.

Delivery Instructions

The names and addresses, fax numbers, or e-mail addresses of intended recipients must be provided so that records can be sent to the appropriate parties. Please specify the records format desired. The options available include hard copy, faxed copy, or imaged copy (pdf format). Faxed records will be sent to the number provided by the requestor, who is responsible for the security of the fax transmission. Imaged documents will be sent via secure e-mail transmission with a passcode communicated to the recipient(s) separately.

Form Submission

Once a form is received requesting patient medical records, it is reviewed for authentication purposes. If the documentation received is acceptable, then the record search is initiated and a response provided within 30 days. If the request is unclear or supporting documentation for legal representation is insufficient or missing, then the requestor will be contacted within 10 days and advised of what is required to initiate the record search. If the requestor fails to provide the required clarification or documentation within 30 days after contact, the request will be deemed invalid and closed. Any future records request will require a new form submission to initiate the process. Please note that, in the event that a records search cannot be completed within 30 days, the requestor will be contacted with a request for additional information and/or additional time up to 30 additional days. If the requestor declines to provide additional information or time for the search, then the records identified to that point will be sent to the requestor and the request considered completed.