

Electronic Record Delivery Request

Complete this form, along with a HIPAA Authorization, to receive your medical records as electronic PDF files rather than as printed copies.

Requester					
Name	First		Last		
Street Address	Street	Suite / Apt #			
	Bilect		Suite / 11	7C II	
	City	S	tate	Zip	
	Email Address for reco	ord delivery			
	Medical Records Re	equested			
Patient Name					
	First	MI		Last	
Date of Birth					
Date of Service	From			То	

Please provide me with the medical records described above through the HealthPort eDelivery online service. I understand and agree that:

- ➤ I must provide a valid email address, either my own or that of my designated recipient.
- ➤ My records will be provided as Adobe PDF files on HealthPort's **eDelivery** website.
- ➤ I will receive an email from **HealthPort.com** containing instructions for accessing my records.
- ➤ If I do not retrieve my records within 30 days, they will be deleted.
- There may be a fee for collecting my records. If so, an invoice will be included with the records.

Signature	Date:
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