UCS Healthcare Patient Request for Records

Patient Name: _____

Date of Birth: _____

Patient Address: _____

Patient City, State, Zip Code:_____

Best Patient Phone Number: _____

Email: _____

1. I, the undersigned, affirm that I am:
   - ❑ the patient named above or
   - ❑ a legally authorized representative/guardian of the patient named.

   I understand that obtaining the requested information under false pretenses is punishable by law.
2. Records to be released to (circle): Requester Other
   - ❑ If Other, please specify _____
3. Purpose of Release:_____
4. Records to be released (labs, health summaries, etc.), please specify date range:

   _____

   _____

   _____
5. Specific categories of treatment receive additional privacy considerations. Please indicate which, if any, of the following records **MAY BE** released:
   - ❑ Mental Health Information
   - ❑ Substance Use Information
   - ❑ HIV/AIDS-Related Information
   - ❑ Other (please specify):_____

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6. How would you like to receive your records?
    - ❑ Encrypted email
    - ❑ Pick up at UCS location (specify location)
        - West Des Moines
        - Ankeny
        - Knoxville
7. If records are being sent to another provider, please provide fax number _____
8. I understand that the person or entity that receives the information requested may not be covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with a covered person or entity and the medical information may no longer be protected by the regulations.
9. I understand that any re-disclosure of these records after I have received them is solely my responsibility, not that of UCS Healthcare.
10. UCS Healthcare does not require the completion of this form as a condition of evaluation or treatment. However, if the evaluation or treatment is solely for the purpose of creating a medical report for a third party, those services are subject to cancellation if authorization to release the information to that party is not provided.
11. This authorization is valid for one year from the date on which it is signed. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance upon it. I understand I have the right to inspect the information to be disclosed upon the proper notification.

Patient/Requester Name (printed): _____

Patient/Requester Signature: _____

Date: _____

Once completed, this form can be dropped off at any UCS location, faxed to 515-883-2683, or mailed to UCS Healthcare, ATTN: Patient Records Request, 1300 Woodland Avenue, West Des Moines, IA 50265.