# 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 # | |
| | | | |
| | City | State | Zip |

| **Email Address for record delivery** |
|---|
| |

| **Medical Records Requested** | | | |
|---|---|---|---|
| **Patient Name** | | | |
| | First | MI | Last |
| **Date of Birth** | | | |
| **Date of Service** | | | |
| | From | To | |

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**:** _____