1055 N 500 W Provo, UT 84604
Phone: 801-429-8062 Fax: 801-374-2615

REQUEST FOR MEDICAL RECORDS

You have the right to inspect or obtain copies of your protected health information which Revere Health maintains. Please complete this form so we can process your request.

Patient Name: _____ **Date of Birth:** _____

Address:_____**City:**_____

State:_____**Zip:**_____ **Phone:** _____

Type of Information Requested (check):

____ Medical Records (dates of service): _____

____ Billing Records (dates of service): _____

____ Radiology Images, CD Only (dates of service): _____

Method of Access Requested (check):

____ Paper copy

____ Electronic copy (CD/DVD)

____ Email* (email address): _____

____ Review in person

(*Note: If we email information it will be in an encrypted format to ensure secure delivery. If you would like the information sent in an unsecured format, which means it could be viewed by unauthorized persons, please initial here: _____.)

Patient/Personal Representative Signature: _____ **Date:** _____

If applicable, name of Personal Representative: _____; and, description of authority to act on behalf of the patient (e.g., Parent, Guardian, Agent appointed under Advance Healthcare Directive):_____.

For Office Use Only:

MRN: _____ Total Pages: _____ Log ID: _____ ROI Clerk Initials: _____