Cleveland Clinic
Martin Health

Patient Request for Health Information

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different from above)			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

What records do you want? (Check appropriate boxes below):

Date(s) of Service: ___/___/___ through ___/___/___

☐ Discharge Summary ☐ Emergency Room Records ☐ Operative/Procedure Reports

☐ Test Results (X-rays, Lab/Pathology Results). Please specify: _____

☐ Other (Immunization Records, Medication Lists) . Please specify: _____

How would you like your records delivered?

☐ Paper ☐ Electronic (CD)

*** Records are $0.50 per page plus postage for records on paper. $6.50 plus postage for records on CD.*

Where do you want the information sent? (Fill in boxes below): Cleveland Clinic Martin Health should provide my records to:

Recipient Name:	Recipient Phone:
Recipient Mailing Address:	Recipient Fax:

Please print your name and sign below:

Name of Patient or Personal Representative: Relationship:

Signature of Patient or Personal Representative Date:

Cleveland Clinic Martin Health recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.