



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: _____