The GYNspace
MAGGIE ABRAHAM MD

## Medical Records Request Form

By signing this form, I authorize **The Gyn Space** to **REQUEST** confidential health information about me, by requesting a copy of my medical records, or a summary or narrative of my protected health information from the physician/person/facility/entity listed below.

Patient name:_____ Date of Birth:_____

The information requested is as follows:

_____

_____

_____

Initial next to each selection to also include:

_____ Mental Health Information

_____ Genetic Testing Information

_____ HIV/AIDS Information

_____ Substance Abuse Diagnosis/Treatment

My health information covering the period from _____ (date) to _____present_____ (date)

Request my protected health information **FROM** the following physician/person/facility/entity:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed name Description of Personal Representative

**SEND** records to: **The Gyn Space**
**Fax:** (716) 214-2318
**Phone:** (407) 743-7471
**Email:** info@thegynspace.com