Thrive Trauma, Inc.
Patient Request for Health Information

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than 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 ____/____/____

Records will be delivered by mail. Where do you want the information sent? (Fill in boxes below):

THRIVE TRAUMA, INC. should provide my records to: ☐ Self ☐ Personal Representative (indicated below)

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (if applicable):

Please print your name and sign below:

Name of Patient or Personal Representative (please print)	Relationship (please print)
Signature of Patient or Personal Representative	Date/Time

Please return completed form to:

Thrive Trauma, Inc. 2101 Magnolia Ave S. Ste 320 Birmingham, Al 35205	E-mail: HIPAA@thrivetrauma.com Fax: (205) 994-6013 Questions? HIPAA@thrivetrauma.com

THRIVE TRAUMA, INC. 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.