STARMARIS ADVANCED PSYCHIATRY CARE LLC
5000 West Colonial Drive, Orlando, FL 32808 | 407-616-1691

HOW TO REQUEST YOUR MEDICAL RECORDS

1. HOW TO REQUEST YOUR MEDICAL RECORDS

Patients may request access to or copies of their medical records. To help us process your request securely and efficiently:

- Complete all applicable sections of this form.
- Clearly identify the records and dates of service requested.
- Select how you want the records delivered and, if applicable, identify the recipient.
- Sign and date the authorization/request.
- Provide accurate contact information so our office can reach you if clarification is needed.
- If acting for the patient, provide documentation of your authority when applicable.
- StarMaris may use reasonable procedures to verify the identity and authority of the requester.

Privacy note: Do not send sensitive medical information through unsecured channels unless instructed.

2. PATIENT INFORMATION

Full Legal Name _____

Date of Birth _____

Address _____

Phone _____

City / State / ZIP _____

Email _____

Preferred Contact Method _____

Patient/Chart ID _____

3. TYPE OF REQUEST

- ☐ I am requesting access to/copies of my own medical records
- ☐ Send my records to another healthcare provider
- ☐ Send my records to another person or organization
- ☐ I would like to inspect/review my records
- ☐ Other

If Other: _____

4. RECORDS REQUESTED

- ☐ Complete medical/psychiatric record
- ☐ Medication-management/progress notes
- ☐ Treatment plan(s)
- ☐ Diagnostic/testing results
- ☐ Discharge/transfer summary
- ☐ Psychiatric evaluation(s)
- ☐ Medication history/list
- ☐ Laboratory results
- ☐ Billing records
- ☐ Other

Dates of service: **From** _____ **To** _____ ☐ All applicable dates

STARMARIS ADVANCED PSYCHIATRY CARE LLC
5000 West Colonial Drive, Orlando, FL 32808 | 407-616-1691

MEDICAL RECORDS REQUEST & AUTHORIZATION

5. RECIPIENT / DELIVERY INFORMATION

Recipient/Provider Name

Practice/Organization

Address

Phone

City / State / ZIP

Fax

Email

Other Secure Delivery Information

Preferred delivery: ☐ Secure electronic ☐ Portal ☐ Fax ☐ Mail ☐ Pickup

6. PURPOSE OF DISCLOSURE

☐ Continuing care ☐ Personal use ☐ Insurance ☐ Legal ☐ Disability/benefits
☐ Transfer of care

Other purpose:

7. AUTHORIZATION & PATIENT RIGHTS

- I authorize StarMaris Advanced Psychiatry Care LLC to use/disclose the health information identified in this form to the recipient above, when applicable.
- I may revoke an authorization in writing, except to the extent action has already been taken in reliance on it.
- Treatment/payment generally will not be conditioned on signing an authorization except as permitted by law.
- Information disclosed to a recipient not subject to HIPAA may no longer be protected by HIPAA, subject to other applicable laws.
- Certain records may have additional confidentiality protections; separately maintained psychotherapy notes may require separate authorization.
- I may request a copy of this signed authorization.

Authorization expiration date/event (if applicable):

8. SIGNATURE

Patient / Authorized Representative Name

Relationship to Patient

Signature (type name if electronic)

Date

Authority to Act for Patient (if applicable)

Phone

9. FOR STARMARIS OFFICE USE ONLY

Date Request Received

Identity/Authority Verified

Method of Verification

Request Type

Date Records Released

Released To

Delivery Method

Processed By