amedisys

Request for Patient Records

Requests for patient records are required to be in writing, but this form is not required if all information necessary is provided for us to complete the request.

Patient/Client Information (* indicates required information)

Patient/Client Name*	Phone
Date of Birth*	Last 4 of SSN or Medical Record Number
Street Address	
City, State, Zip	
Amedisys Agency or Location	
This is a ❑ Current Patient ❑ Former Patient	
Dates of service	

Information Requested (check all applicable)

I want the records for the following timeframe (if unmarked, we will assume all time)

❑ All time

❑ A specific date range (please estimate if you do not remember exact dates)

From _____ to _____

I want the following records (mark all that apply; if unmarked, we will assume complete record)

❑ Complete Medical Record*	❑ Visit Notes	❑ Doctor's Orders	❑ History/Physical
❑ Billing Records	❑ Plan of Care	❑ Discharge Summary	❑ Consultations
❑ Medication Records	❑ Abstract	❑ Discharge Instructions	❑ Lab Reports
❑ Other (Please Specify)			

*Complete medical record may be hundreds of pages. Complete medical record does not include billing records.

I understand that medical and billing records may include records pertaining to psychiatric treatment or mental health including but not limited to psychotherapy notes, sexually transmitted disease, HIV and AIDS, alcohol and substance abuse, and genetic information, if applicable. Unless otherwise instructed, I am requesting access to these records.
(Please indicate/cross out any information you do not want to access.)

Delivery Method and Format

Except for requests for paper records, records will be provided in PDF format unless otherwise specified.

❑ Pick up in person (paper records only)	
❑ Clinician to deliver paper records during upcoming visit (for current patients only)	
❑ Sent by email (This option is available if the records are maintained electronically)	Email address:
❑ Mailed to the following address as: ❑ Paper documents ❑ PDF on CD (Unless otherwise specified, records will be provided on an encrypted CD)	Address where records are to be sent:

Signature of Requestor

Signature of Requestor	Printed Name of Requestor
Date	Relationship to Patient/Client (if not a Patient/Client request)

Instructions for completing this form

1. Completing all sections of this form is encouraged. Incomplete or inaccurate forms may result in the request being delayed.
2. If the Patient/Client is deceased, please provide documentation to show you have authority to act on behalf of the patient (e.g., copy of death certificate and proof of executorship).
3. Please send your request (and documentation of authority, if required) to the Amedisys medical records team as listed below or in person to the Amedisys location providing care.
4. Additional identity verification may be required to process this request. We will contact you if additional verification is required.
5. For any questions regarding the release of medical information, you may contact the Medical Records team using the methods listed below.

Contact Amedisys Medical Records Department

Amedisys Attention: Medical Records 3854 American Way, Suite A Baton Rouge, LA 70816	Phone	855-475-2938
	Fax	877-881-0043
	Email	MedicalRecords@amedisys.com