



Medical Records Request Form

By signing this form, I authorize **Bliss Direct Primary Care** 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:

Bliss Direct Primary Care

Address: 5850 Town and Country Blvd, Building 10, Suite Number 1003 Frisco, TX 75034

Fax: 469-981-1303

Phone: (469) 908-4752

Email: info@blissdpc.com