Electronic Record Delivery Request

Complete this form, along with a HIPAA Authorization, to receive your medical records as electronic PDF files rather than as printed copies.

Requester Name	First		Last
Street Address	Street		Suite / Apt #
	City	State	Zip

Email Address for record delivery

Medical Records Requested			
Patient Name	First	MI	Last
Date of Birth			
Date of Service	From		To

Please provide me with the medical records described above through the Ciox Health eDelivery online service. I understand and agree that:

- I must provide a valid email address, either my own or that of my designated recipient.
- My records will be provided as Adobe PDF files on Ciox Health **eDelivery** website.
- I will receive an email from **CioxHealth.com** containing instructions for accessing my records.
- There may be a fee for collecting my records. If so, an invoice will be included with the records.

Signature ______________________________ **Date:** __________