



5315 Avion Park Drive, Suite 120, Tampa, Florida 33607
Phone: 844-650-5802 Fax: 844-277-0049

Request to Access Records

What Patient?	
Patient Name	Date of Birth
Address	Telephone #
For What Time Period?	
I am requesting data for the following timeframe.	Start Date: _____ End Date: _____
What Information?	
Please describe the Information you wish to have access to and in what format (we will try to comply with the format if possible):	
<input type="checkbox"/> Medication Expense	
<input type="checkbox"/> Other (Please provide detail)	
Who do you want information sent to?	
<input type="checkbox"/> Patient/Personal Representative (Please indicate how you would like to receive this information (i.e., Pick-up, Mail, Emailed (emails are not secure and not recommended))	
<input type="checkbox"/> Individual or Entity (Please provide name, address, and instructions to send information)	

If the records are being requested for a spouse, child that is above the Age of Medical Consent or other individual, they will be mailed directly to the patient. .

I understand that if the Practice grants access to records, they will provide the requested records within thirty (30) days. Also, I understand there may be a cost-based fee charged to process this request and the Practice will contact me prior to continuing action on this request for my acceptance of the fee amount (if any). If the Practice needs additional time, then the Practice's Privacy Officer will notify me with the reason.

When completed, please return to
IV Solutions RX
5315 Avion Park Drive Suite 120
Tampa, FL 33607
info@ivsolutionsrx.com

Signature of Patient/Legal Guardian/Personal Representative	Relationship to the Patient.	Date