Apothicor LLC Patient Medical Record Request

I, _____ request that Apothicor LLC provide a Medical Record for the individual(s) listed below. I understand that Apothicor LLC may only release records pertaining to me, my dependents or those of individuals for whom I am a personal representative for.

Authorization Request

I understand that requests for an individual other than myself (listed below) will require either the submission of a separate medical record request or valid authorization (ex. power of attorney) signed by that individual and attached to this form.

Individuals for whom medical record is requested;

Patient Name	Date of Birth	Relationship
_____	__/__/____	_____
_____	__/__/____	_____
_____	__/__/____	_____

_____ __/__/____
(Signature of patient or authorized representative) (Date)

Address:

Verification of Identity:

*Ensure authorized documentation is attached if the individual requesting records is not the patient themselves or a dependent under the age of 18 years old; store this document in designated file in accordance with Privacy Policies and Procedures. Contact your privacy officer with questions.