

Last Name	First Name	M.I.	TRS# (office use)
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**Request to Release Medical Records for Personal Use**

Tri Rivers Surgical Associates, Inc. (The "Practice")

**The Practice will permit you to inspect and obtain a copy of most of your medical information maintained at the Practice. We may deny your request to inspect and copy in certain limited circumstances.**

I, \_\_\_\_\_, *(Name of patient or patient's representative)* hereby request to inspect and copy protected health information in my medical record, as described below.

**Please provide a specific description of the type of information to be released, including dates. Be as specific as possible regarding what medical information you are requesting to have released.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Patient Date of Birth:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Please indicate how you would like to receive the information:**

- By mail
- Pick-up at the Practice office in:  North Hills  Cranberry/Mars  Butler
- By fax at this number: \_\_\_\_\_

\_\_\_\_\_  
*(Signature of patient or patient's representative)*

\_\_\_\_\_  
*(Date)*

\_\_\_\_\_  
*(Printed name of patient or patient's representative)*

<b>Completed forms may be sent to the fax number or mailing address below.</b>	
<b>Fax:</b> (412) 630-8019 Attn. Forms & Medical Records Dept.	<b>Mail:</b> Tri Rivers Surgical Associates Attn. Forms & Medical Records Dept. 9104 Babcock Blvd., Suite 2120 Pittsburgh, PA 15237