Salud Family Health

Request of Records for Continuity of Care

This form is for healthcare providers to request health records for the purpose of providing ongoing medical, dental and/or behavioral health care. Please fax the completed form to 303 227 2779. **Urgency of request** ☐ **Urgent** ☐ Routine

Patient Information

Patient Name (First, Middle, Last)	Date of Birth (mm-dd-yyyy)
Previous or Maiden Names (if applicable) (First, Middle, Last)	Salud Account Number (if known)

Requesting Healthcare Provider's Information	Preferred Delivery Method
Facility Name	☐ Printed copy of records will be mailed to the nominated address.
Requester's Name	☐ Electronic Copy (Email in section 2) As a healthcare entity, we are required by HIPAA regulations to encrypt our email messaging correspondence to ensure confidentiality. If you choose to receive emails from us, you will be prompted to enter a password before accessing them. We advise you to choose this option of communication only if you are aware of the risks and understand them.
Street	
City	
State | ZIP	
Phone	
Fax	☐ Fax (number listed to left)
Email	

Records to be Released

Timeframe to be released ☐ Last 2 years ☐ Last year ☐ All dates ☐ **Dates: From**_______________ **To**_______________

Document/Note(s) (check all that apply)

☐ Behavioral Health/Mental/Psychological notes ☐ Medical Provider Notes ☐ Physical Exam ☐ Last Dental Exam

☐ Dental Notes ☐ Other Specify

Additional Records (check all that apply)

☐ Immunizations Medication list ☐ Laboratory Results HIV Lab test results ☐ EKG(s)/Cardio/Echo Radiology report(s)

☐ Radiology image(s), specify exam(s)/body part(s) ☐ Pathology report(s) ☐ Genetic testing ☐ Dental Images ☐ Billing Info

Substance Abuse and Addiction Treatment Records (check all that apply)

☐ Assessment/Evaluation Multidisciplinary notes ☐ Family Participation Invitation ☐ Treatment plans

☐ Other Specify

Other, specify if applicable

Specify