

**MEDICAL RECORDS REQUEST**

**Fax Response to 888-209-4417**

TO:	RE:
NPI:	
PH:	PH:
FAX:	DOB:
DATE:	REF. ID:

I am requesting a copy of my medical records to be faxed and/or sent to the following:

Method HCS  
205 S. State Street #602  
Orem, UT 84058

Fax: 888-209-4417

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights regarding my protected health information. I understand that I may obtain a copy of my Medical Records. If there are charges for this request, please advise me first for my approval. Thank you.

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Signature