



Medical Records Request (ROI)

At **Rejuv Medical**, we are committed to providing patients with convenient and secure access to their health information. Many records are available for download through the **Athena Patient Portal**, where you can securely view and share your information with other providers. If you would like Rejuv Medical to release records on your behalf, please complete this form. Requests are typically processed within **5–10 business days** and no later than **30 calendar days**. Printed copies are available at **\$0.25 per page**, charged to your patient account.

Patient Information	Full Name: _____	Date of Birth: _____
	Address: _____	Contact #: _____
	City: _____ State: _____	Zip Code: _____
Release Information FROM	Specific (Provider / Clinic / Hospital / Facility): _____	
	Address: _____	Contact #: _____ Fax #: _____
	City: _____ State: _____	Zip Code: _____
Release Information TO	Name of Person / Business / Clinic / Hospital / Provider: _____	
	Address: _____	Contact #: _____ Fax #: _____
	City: _____ State: _____	Zip Code: _____
Information to be Released	Date(s) of service: From: _____ To: _____	
	<p>*Note: If dates of service are not specified, records from visits on or after April 15, 2025, up to the most recent encounter will be released.</p> <p> <input type="checkbox"/> All Charts (excluding imaging) <input type="checkbox"/> *Imaging on CD <input type="checkbox"/> Lab Results Only <input type="checkbox"/> Medication List Only <input type="checkbox"/> Physical Therapy Notes Only <input type="checkbox"/> Itemized Billing Statement <input type="checkbox"/> Other (please specify) _____ Exclude: <input type="checkbox"/> Mental Health <input type="checkbox"/> Other (please specify) _____ </p>	
Special Disclosure	Date(s) of service: From: _____ To: _____ <input type="checkbox"/> Mental Health <input type="checkbox"/> Alcohol/Drug Abuse Treatment <input type="checkbox"/> Communicable Disease (HIV, AIDS) <input type="checkbox"/> Other (please specify) _____	
Preferred Method	<input type="checkbox"/> Pick-Up <input type="checkbox"/> Mail <input type="checkbox"/> Email, Email Address: _____ <input type="checkbox"/> Fax *Radiology Imaging (CD): <input type="checkbox"/> Pick-Up <input type="checkbox"/> Mail	
Reason for Release	<input type="checkbox"/> Continuation or Transfer of Care (to another provider) <input type="checkbox"/> Personal Use <input type="checkbox"/> Attorney <input type="checkbox"/> Insurance <input type="checkbox"/> Other (please specify) _____	
This authorization will expire one year from the date I sign unless I indicate a different date or event: _____		
<ul style="list-style-type: none"> I understand that I have the right to revoke this authorization in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law. Requests for Protected Health Information are typically processed within 5–10 business days and will be completed no later than 30 calendar days. Printed copies are available at a cost of \$0.25 per page, which will be charged to my patient account. 		
Authorization	Patient / Guardian Signature _____	Date _____
	Relationship to Patient _____	