McLaren

MEDICAL GROUP

Electronic Record Delivery Request

Complete this form, along with an Authorization to Release Medical Information form, to receive your medical records as electronic PDF files rather than as printed copies.

Requester Name			
	First	Last	
Street Address			
	Street	Suite / Apt #	
	City	State	Zip

Email Address for record delivery

Please provide me with the medical records described on the Authorization to Release Medical Information form through the HealthPort eDelivery online service.

I understand and agree that:

- I must provide a valid email address, either my own or that of my designated recipient.
- My records will be provided as Adobe PDF files on HealthPort's **eDelivery** website.
- I will receive an email from **HealthPort.com** containing instructions for accessing my records.
- There may be a fee for collecting my records. If so, an invoice will be included with the records**.**

Signature: _____ Date: _____

OFFICE USE ONLY- ENSURE FORMS ARE COMPLETED IN THEIR ENTIRITY. *FAX THIS FORM **AND** THE AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO:*

FAX # (810) 342-1519.

Also, call Healthport at (810) 342-1552 and leave a message with the patient's name regarding the faxed request. This is to ensure Healthport receives the fax and responds within the required timeline.