Patient Health Information Request Form

Please complete and return this form to your healthcare provider. Your healthcare provider will submit this form to Manifest MedEx.

Patients have the right to request a copy of their health information that is available through Manifest MedEx ("MX"), a California health information exchange (HIE).

If you want to request a copy of your health information, please complete and return this form to your healthcare provider. Your healthcare provider will complete their portion of the form and submit it to MX.

The healthcare provider must be a participant in the MX network:
https://www.manifestmedex.org/our-network/participants/

You will receive a response to your request from MX within 30 days of MX receiving the completed form from your healthcare provider. Please note MX will only send data to an address within the United States of America or its territories. If you are filling out this form for another person, the references to "I" and "my" in this form refer to that other person.

Patient First and Last Name:_______________________________**Date of Birth**:______________

Street Address:____

City:__________________________________**State**:______________**Zip**:______________________

Please check all boxes that apply:

- ☐ Please mail my health information to the above address.
- ☐ Please EMAIL my health information via secure messaging to me at the following email address:

________________________________ [Patient please provide your email address here]

Signature of Patient or Patient's Parent /Guardian /Caregiver with authority to make healthcare decisions:

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Print Name:____**Date**:___________________________

If signed by a person other than the patient, please indicate your authority to sign for the patient (check one):

☐ Parent/Guardian ☐ Caregiver with authority to make healthcare decisions

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Provider Office Use Only: Provider, please complete this section. Manifest MedEx will not respond to forms without this section completed. This authorizes Manifest MedEx to share health records with the patient indicated on this form.

To submit the completed form to MX, first send an email to Support@manifestmedex.org with only "Need to submit patient data access form" in the subject line. MX will respond to your email with a ***secure*** email confirming that you may send the form to MX by responding to the secure email. Do not send the form to MX without first receiving a secure email confirmation.

Organization/Provider:____

Print Name:________________________________

Title:____________________________________

Date:____________________________________

Medical Record Number for Patient Requesting Data: ______________________________

Signature:__________________________________

Email: ________________________________

Phone:___________________________________