

## Zinnia Health Medical Records Request Form

Date of Submission \_\_\_\_\_

Client's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_

Home Address \_\_\_\_\_

Daytime Telephone \_\_\_\_\_ Evening Telephone \_\_\_\_\_

Fax \_\_\_\_\_ Email \_\_\_\_\_

I would like my records sent via: \_\_\_\_\_ Email \_\_\_\_\_ Fax \_\_\_\_\_ U.S. Mail\*

**Client to initial selection(s) above**

Note: **Zinnia will not send records unless at least one of these 3 lines INCLUDES CLIENT INITIALS.** Regarding email requests, please note that there is some level of risk that a third party could see your protected health information ("PHI") without your consent when you use email. We are not responsible for unauthorized access to the PHI contained in this format or any unintentional risk (e.g., virus) introduced to your computer/device when receiving PHI via email. Please allow 10 business days to complete your request. \*Postage fees will be the client's responsibility.

Please list the specific documents you are requesting:

\_\_\_\_\_  
\_\_\_\_\_

Purpose of Request:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

**\*Client must include copy of photo ID with this completed form.**

Requestor's Name (if applicable) \_\_\_\_\_

\_\_\_\_\_  
Signature of Requestor

\_\_\_\_\_  
Date

Please send this form to [recordsrequest@zinniahealth.com](mailto:recordsrequest@zinniahealth.com)