

## PATIENT RECORDS - COPYING REQUEST FORM (PATIENT TRANSITIONING TO ANOTHER PROVIDER)

Patient's Name:				
(please print)	Last	First	Middle	
Home Address:				
Home Phone:	Date of Birth:			
			le me with a copy of my medical re to another pr	
Please send my records to:				
New provider	's name:			
Attention:				
New provider	's address:		<u> </u>	
I understand that:				
not include informa		le anticipation of (or fo	e information older than six (6) year r use in) a civil, criminal or adm	
<ul> <li>Apria may deny this privacy of health info</li> </ul>		rumstances as provided f	or under federal and state law prot	ecting the
I may be charged for	a copy of my records, in ac	ecordance with applicable	e federal and state laws.	
Signature of Patient (or Personal Representative)		Date		
Printed Name of Patient (or Personal Representative)		Relationship of Perif applicable	rsonal Representative to Patient,	

After you have completed, signed, and dated this form, please return it using one of the following methods:

- Mail: Apria Healthcare, 1340 S. Highland Ave., Jackson, TN 38301 Attn: PPMC
- Facsimile: (949) 238-5810.
- Email: PPMC@apria.com

(Warning: Communications via email over the internet in general, and via unencrypted email in particular, are not secure and there is a possibility that information included in an email can be misdirected or intercepted and read by other parties besides the person to whom it is addressed.)