



Instructions to Request Medical Files

Please follow the steps below in order to receive your medical file:

1. All requests for medical records (Quick Contact request at www.veritrust.net, phone, mail, and fax) require completion of Patient Authorization for Release of Medical Records Form
2. The Release of Medical Records form can be found at: <http://store.veritrust.net>
3. Fill out the Release form and mail the **ORIGINAL**, along with a copy of a valid government ID to:
PO Box 22737
Houston, TX 77227
4. Once the signed form is received, you will be provided with a secure link where you will be able to purchase and download your medical file.
5. Those requests involving image CD records, will be provided with an alternate link to pay for the file and shipping. Receipt will be made via 3rd party (Fedex or other) carrier.
6. Please allow 7-10 days for processing from when we receive your Release to your delivery/download. Rush requests will be handled on a case by case basis.

If you have any questions, you may contact us at (713) 263.9000 or at medicalrecords@veritrust.net



**Patient Authorization for Release of Medical Records
And Disclosure of Protected Health Information**

By signing this authorization, I authorize VeriTrust to retrieve, and/or disclose, as well as transmit certain Protected Health Information (PHI):

Doctor's Name _____

Patient Name _____

Address _____

City, State, Zip _____

Date of Birth: _____ Social Security #: _____

Phone: _____ E-Mail: _____

Legal Guardian / Parent authorizes release of medical records (same as above if patient is self):

Name _____

Address _____

City, State, Zip _____

Driver's License # or Government Issued ID: _____

Phone: _____ Fax: _____

This authorization permits VeriTrust to retrieve, use and/or disclose to me, my legal guardian or the physician of my choosing; medical or health information records. Additionally, this authorization permits VeriTrust to deliver records to the identified address via 3rd Party (ex. Fedex, UPS, DHL) shipment. When my information is disclosed pursuant to this authorization, it may be subject to re-disclosure by patient or patient's representative and may no longer be protected by the federal HIPAA Privacy Rule.

VeriTrust must receive this signed authorization prior to release of any medical or patient records along with any associated fees that will be incurred to process this request;

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Print Name of Patient or Legal Guardian Date

**ORIGINAL SIGNATURE MUST BE RECEIVED IN ORDER FOR RECORD TO BE RELEASED
SEND FORM TO PO BOX 22737 HOUSTON, TX 77227
(Please include a photocopy of a government issued ID)**