LIGHTHOUSE
CONVENIENCE CLINIC

Lighting the way to healthcare freedom.

145 W US Hwy 54 • Camdenton, MO 65020
573-873-7138 • info@lcclinic.org • www.lcclinic.org

Personal Health Information Records Request

Name of Patient: _____

Date of Birth: _____

Mailing Address:

_____

_____

Phone Number: _____

Email Address (if requesting records to be sent electronically):

_____

Notice: Email is an insecure method of transmission that can be intercepted as it travels over the internet. Once the medical records are received, they can be copied, redistributed and may no longer be protected by the HIPAA rules and regulations. As a result of your informed consent, we will send the requested protected health information to you via the email address you provided.Please note: Email accounts are subject to criminal attack and any protected health information received could be viewed or stolen.

I am requesting that the medical records of the above named patient be sent via:

- ☐ USPS Mail
- ☐ Email

_____ _____

Signature Printed Name and Relationship to Patient

The following fees apply for providing your medical records. Please check all that apply and remit payment accordingly:

- ☐ Medical Records: $10
- ☐ CD of X-ray: $5
- ☐ Shipping and handling fee: $5 (if delivery via USPS Mail is requested)

_____: Total Remit Payment to: Lighthouse Convenience Clinic LLC

Mail form and payment to:
Lighthouse Convenience Clinic LLC, PO Box 705, Camdenton, MO 65020