APRIA HEALTHCARE®

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:** _____

I am a patient of Apria Healthcare ("Apria") and hereby request that Apria provide me with a copy of my medical records, so I may transition my [insert type of equipment] _____ to another provider.

Please send my records to:

New provider's name: _____

Attention: _____

New provider's address: _____

_____

I understand that:

- Any information provided to me pursuant to this request may not include information older than six (6) years and will not include information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be limited or restricted by applicable law.
- Apria may deny this request under limited circumstances as provided for under federal and state law protecting the privacy of health information.
- I may be charged for a copy of my records, in accordance with applicable federal and state laws.

_____ _____
Signature of Patient (or Personal Representative) Date

_____ _____
Printed Name of Patient (or Personal Representative) Relationship of Personal Representative to Patient, if applicable

* * * * *

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.)