

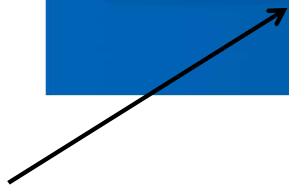
HOME ► ELECTRONIC REQUEST FOR MEDICAL RECORDS

Electronic Request for Medical Records

Easily request your medical records with our online request system

[Click Here to Place a Request for Medical Records](#) 

Click Here





Patient Release of Information

Request medical records from LifeBridge Health

Before you begin

- Have your photo ID ready
- Make sure your device has a camera
- We recommend using Chrome, Firefox, or Safari browser

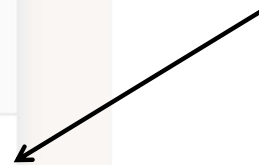
This should take approximately 5 to 10 minutes to complete.

If you have a New Hampshire driver's license, please prepare another form of government ID such as a passport. If your only form of photo identification is a New Hampshire driver's license, please contact your provider for assistance with requesting your medical records.

[Share this link](#)

[I'm ready, let's get started! →](#)

Click Here



[< Back](#)[Quit ×](#)

Which location would you like to request from?

☐ Hospitals☐ Primary Care Offices☒ Cardiology Offices☐ Neurology

Select This



← Back

Quit ×

Which location would you like to request from?

Cardiology Offices

☐ Cardiac Electrophysiology

☐ Sinai Cardiovascular - Mirowski

☐ Cardiovascular Associates - Greenspring Valley

☒ Cardiovascular Associates - Najafi

☐ CHG - Cardiology

Select This



[← Back](#)[Quit ×](#)

Are you requesting your own records?

☒ **Yes, I'm the patient**

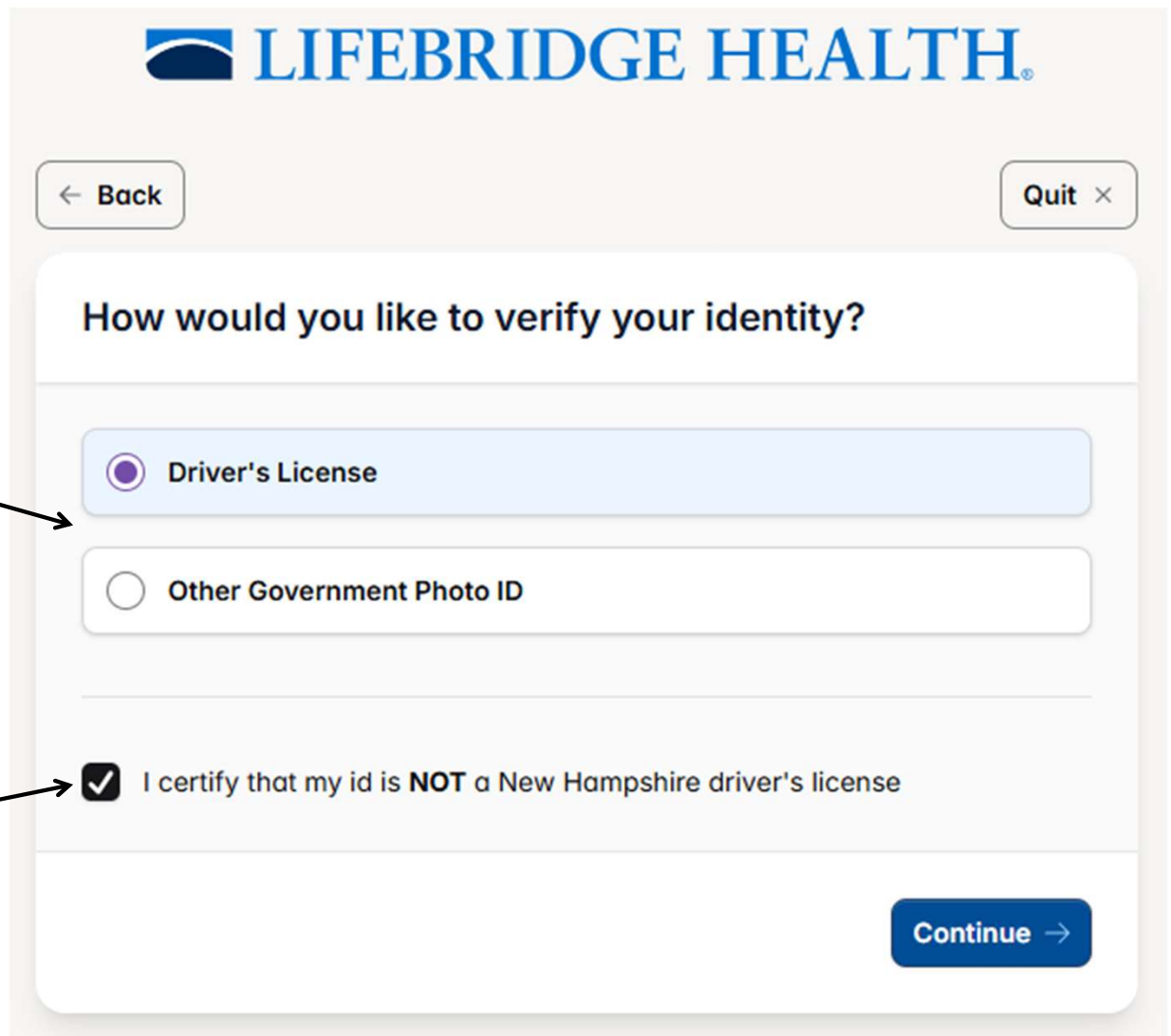
☐ **No, I'm requesting for someone else**

You will need to confirm your relationship to the patient by uploading supporting documentation

Continue →

Select that you are the patient, then click continue.

**First, select
the form of ID
that you have.**



The screenshot shows a web form for LifeBridge Health. At the top is the LifeBridge Health logo. Below the logo are two buttons: "Back" with a left arrow and "Quit" with a close icon. The main heading of the form is "How would you like to verify your identity?". There are two radio button options: "Driver's License" (which is selected) and "Other Government Photo ID". Below these options is a checkbox that is checked, with the text "I certify that my id is NOT a New Hampshire driver's license". At the bottom right of the form is a blue "Continue" button with a right arrow.

LIFEBRIDGE HEALTH

← Back Quit ×

How would you like to verify your identity?

☒ Driver's License

☐ Other Government Photo ID

☒ I certify that my id is **NOT** a New Hampshire driver's license

Continue →

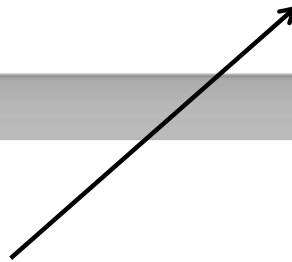
**You must
check this box
before it lets
you continue.**

Camera Permission Needed

This next step requires your camera to take a photo of your ID. Please click **Allow** if you are asked for permission to use the camera.

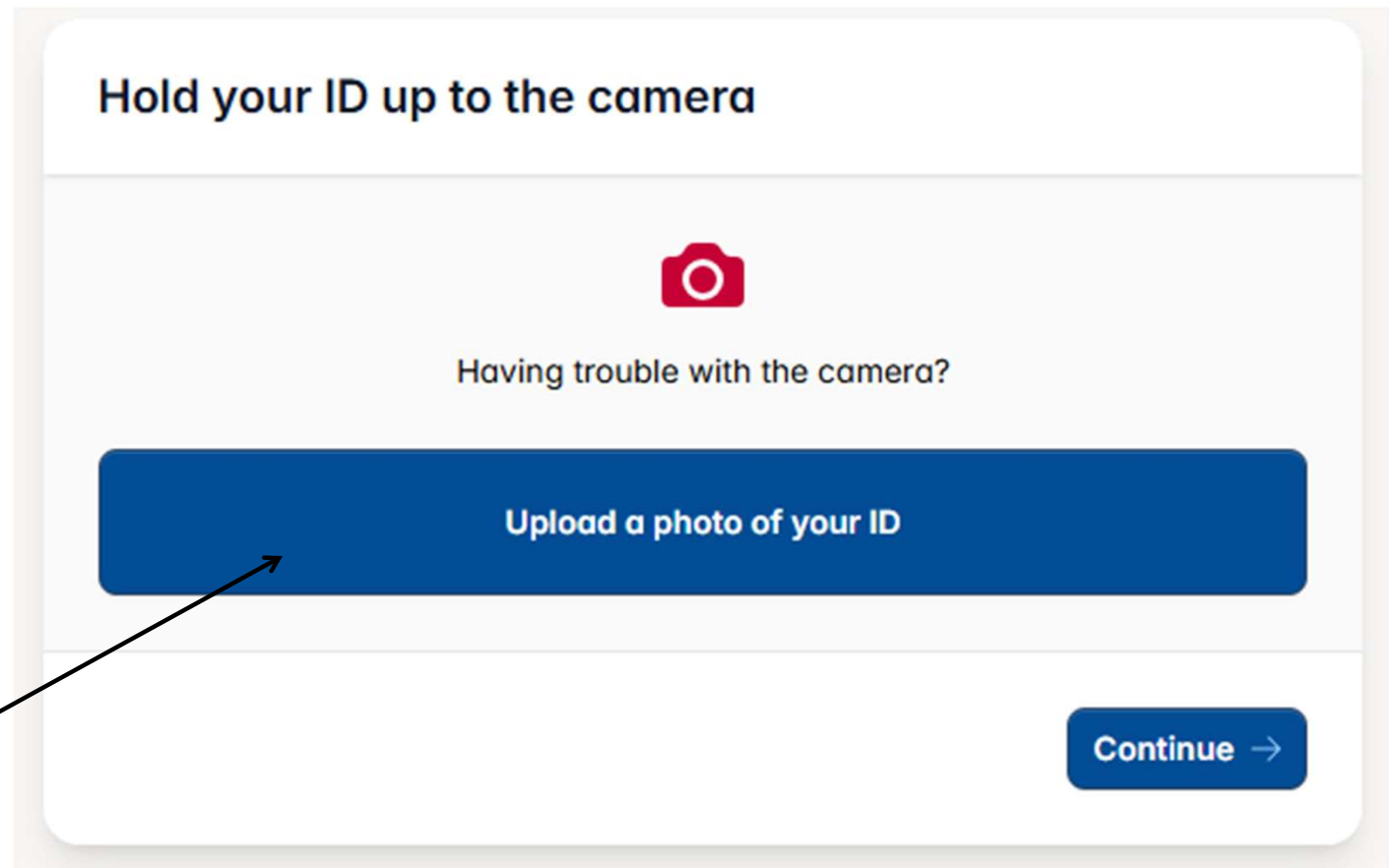
Got it!

**Allow access to
your camera by
clicking this.**



If you are using your cellphone, take a photo of your ID then click continue.

If you are using a computer, click here to upload a saved picture of your ID then click continue.



Hold your ID up to the camera



Having trouble with the camera?

Upload a photo of your ID

Continue →

The screenshot shows a mobile app interface for ID verification. At the top, it says "Hold your ID up to the camera". Below this is a red camera icon. Under the icon, it asks "Having trouble with the camera?". There is a large blue button labeled "Upload a photo of your ID". An arrow from the text on the left points to this button. In the bottom right corner, there is a blue button labeled "Continue →".

Type your email address in both boxes.

Checking this box is optional before continuing.

What is your email address?

We'll email you a confirmation of this request once you're finished

Email address



Verify email address



☐ Please email me a copy of my completed request form
This will include personally identifiable, Protected Health Information (PHI) and/or sensitive information such as name, address, and types of medical records requested

[Continue →](#)

Submit your cellphone number in this step.



Please enter your phone number

We will use this number if we need to follow up with you regarding this request

Phone Number

Continue →

If your name has changed since your last visit at our office, click here to include the previous name that was used before continuing.

What is your full legal name?

This should be your legal name at the time of service (maiden name or other)

First Name

Jane

Last Name

Smtih

Middle Name (optional)

Austin

☐

Check this box if name has changed since visiting this provider

Continue →

What is your mailing address?

Enter house number and street name only please. Include apt/suite number if applicable.

Street Address

123 Sesame St

ZIP Code

21015

City

Bel Air

State

Maryland

Continue →

Submit your current address here before continuing.

What is your date of birth?

Month

Day

Year

Continue →

Submit your birthday before continuing.

To whom should we release these medical records?

☐

Me (the Patient)

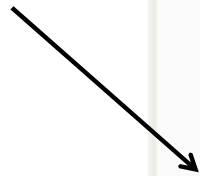
☒

A third party (doctor, other)

Continue →

Select this option, then continue.

**Please make sure
this box is checked
before continuing.
We do not need
these records.**



Sensitive Records Disclosure

Acknowledgement

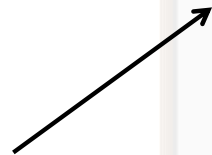
If the records that I have requested contain any information related to HIV/AIDS, sexually transmitting infections, substance use disorder and/or mental health treatment, genetic testing, or sexual and reproductive health care, I consent to the disclosure of such information by LifeBridge Health to the party or parties authorized within this tool.



I want to limit the release of sensitive information

Continue →

These will be automatically selected. Please unselect each box before continuing.



Your request can contain sensitive information

Any checked items may be included in your request

☐

HIV Test Results

☐

Behavioral/Mental Health Records

☐

Substance Abuse Information

Continue →

How should we release these medical records to the third party?

☐

Fax

LifeBridge Health will only fax records directly to other healthcare providers for continuing care.

☒

Mail

Continue →

Select mail,
then continue.



To whom should we release the records?

If sending to a doctor, include the full name or practice name. We'll ask for the address in the next step.

Name/Organization

Dr. Amir Najafi- Integra Heart

Continue →

Type this in
exactly as shown,
then continue.

**Fill in our business
address as shown,
then continue.**

What is the delivery mailing address?

Enter house number and street name only please. Include apt/suite number if applicable.

Street Address

2021B Emmorton Rd Ste. 110

ZIP Code

21015

City

Bel Air

State

Maryland

Continue →

**Select CD/DVD,
then continue.**

What format would you like the records in?

☒ CD/DVD

☐ USB Drive

☐ Paper

Continue →

Select continued care, then continue.

What's the primary reason for requesting records?

This is optional, but may help us better fulfill your request



Continued Care

Seeing another provider for continuing, transferring, or referral of medical care or treatment



Patient Request

Records to keep for your own personal file



Maternal Health

Records related to a pregnancy



Insurance



Legal



Other

Continue →

Select this option.

**For the start date,
please enter
January 1st, 2023.**

**For the end date,
please enter
yesterday's date.**

What time period should we search for records?

☐ Last 6 months (recommended)

☒ I want to specify a date range

Start Date

01 - January 01 2023

End Date

- Select -

Continue →

Which types of medical records would you like?

Check any that apply



Essential Record Set

The "Essential Record Set" includes many critical document types, including Procedure Reports, Provider Notes, History and Physical Exam Notes, Discharge Summaries, Radiology/Diagnostic Reports, and Lab Reports.



Select specific record types

Continue →

Select this option.

Please fill this section out with the following request.

Great, almost done! Please provide any details you think may be helpful for this request.

This is optional but may help us better fulfill your request

Additional Details

Please also submit my records digitally to Integra Heart's EHR.

Continue →

Review all of the information to confirm that your personal information is correct and confirm that our information is written correctly as shown.

Here's a preview of your request form

We're almost done! Please review carefully and continue when you're ready to sign.



AUTHORIZATION FOR
RELEASE OF MEDICAL
INFORMATION

Bar Coded Patient Label

Location(s) of Care:
Hospital/Physician Practice Cardiovascular Associates - Najafi

Smith, Jane Austin

Patient's Name (print)

123 Sesame St

Patient's Street Address

Bel Air, MD 21015

City, State, Zip Code

6/6/1988

Phone Number

Patient's Date of Birth

janesmith@email.com

e-mail address

Purpose of
Request: Continued Care

I, the undersigned, hereby authorize Cardiovascular Associates - Najafi

☒ to release copies of medical records to: Dr. Amir Najafi- Integra Heart - Mail CD/DVD

☐ to obtain copies of medical records from:

Date(s) of Service: 1/1/2023 - 8/9/2026

Type of records being requested (check all that apply):

☒ Abstract (Summary, Op
Report, Paths, Consults,
H&P, lab work)

☐ Emergency Room Record

☐ Alcohol / Detox /
Drug Abuse

☐ X-ray, EKG, EEG, Labs,
Cardiopulmonary

Person/Company that you wish to receive your records:

Dr. Amir Najafi- Integra Heart - Mail CD/DVD

Name:

Bel Air, MD 21015

Address

Request Summary

Requestor

janesmith@email.com

(555) 555-5555

Send copy to requestor

Yes

Patient

Jane Austin Smith

123 Sesame St

Bel Air, MD 21015

DOB: 6/6/1988

Delivery

Mail / CD/DVD

Destination

A third party (doctor, other)

Dr. Amir Najafi- Integra Heart

2021B Emmorton Rd Ste. 110

Bel Air, MD 21015

Purpose

Continued Care

Additional Details

Please also submit my records digitally to Integra Heart's EHR.

Location

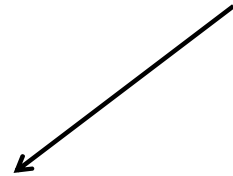
Cardiovascular Associates - Najafi

Date Range

Custom: 1/1/2023 to 8/9/2026

Records Requested

• Essential Record Set



Review all of the information to confirm that your personal information is correct and confirm that our information is written correctly as shown.

If everything is correct, click continue.



Continue →

You may choose to draw a signature or generate an electronic signature.

Make sure this box is selected before continuing.

How would you like to sign?

☒ Draw your signature

Use the signature pad to sign by hand

A signature pad with a dashed line. A handwritten signature is written on the line. A 'Clear' button is in the top right corner.

☐ Generate a signature

☒ I understand this is a legal representation of my signature.

I understand that by signing this authorization I am affirming that this is my electronic signature, I am personally signing this document, and this signature shall have the same legal effect, validity and enforceability as a manually executed signature to the fullest extent permitted by applicable law, including the Federal Electronic Signatures in Global and National Commerce Act, the New York State Electronic Signatures and Records Act and any other applicable law, including, without limitation, and state law based on the Uniform Electronic Transactions Act or the Uniform Commercial Code.

[Continue →](#)

Review all of the information to confirm that your personal information is correct and confirm that our information is written correctly as shown.

Review and submit your request

This is your complete request including all information, photo ID, and signatures. Review and submit when you're ready.

 **LIFEBRIDGE
HEALTH.**
CARE BRAVELY



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Bar Coded Patient Label

Location(s) of Care:

Hospital/Physician Practice Cardiovascular Associates - Najafi

Smith, Jane Austin

Patient's Name (print)

123 Sesame St

Patient's Street Address

Bel Air, MD 21015

City, State, Zip Code

6/6/1988

Patient's Date of Birth

Phone Number

janesmith@email.com

e-mail address

Purpose of

Request: Continued Care

I, the undersigned, hereby authorize Cardiovascular Associates - Najafi

☒ to **release** copies of medical records to: Dr. Amir Najafi- Integra Heart - Mail CD/DVD

☐ to **obtain** copies of medical records from:

Date(s) of Service: 1/1/2023 - 8/9/2026

Type of records being requested (check all that apply):

☒ Abstract (Summary, Op
Report, Paths, Consults,
H&P, lab work)

☐ Emergency Room Record

☐ Alcohol / Detox /
Drug Abuse

☐ X-ray, EKG, EEG, Labs,
Cardiopulmonary

Person/Company that you wish to receive your records:

Dr. Amir Najafi- Integra Heart - Mail CD/DVD

Name:

Bel Air, MD 21015

Address

Request Summary

Requestor
janesmith@email.com
(555) 555-5555

Send copy to requestor
Yes

Patient
Jane Austin Smith
123 Sesame St
Bel Air, MD 21015
DOB: 6/6/1988

Delivery
Mail / CD/DVD

Destination
A third party (doctor, other)
Dr. Amir Najafi- Integra Heart
2021B Emmorton Rd Ste. 110
Bel Air, MD 21015

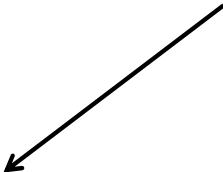
Purpose
Continued Care

Additional Details
Please also submit my records digitally to Integra Heart's EHR.

Location
Cardiovascular Associates - Najafi

Date Range
Custom: 1/1/2023 to 8/9/2026

Records Requested
• Essential Record Set



Review all of the information to confirm that your personal information is correct and confirm that our information is written correctly as shown.

If everything is correct, click submit my request.



Submit my request

The survey page after submitting your request is optional. If you do not want to do it, select skip.

When you are successfully done, you will see this page.

