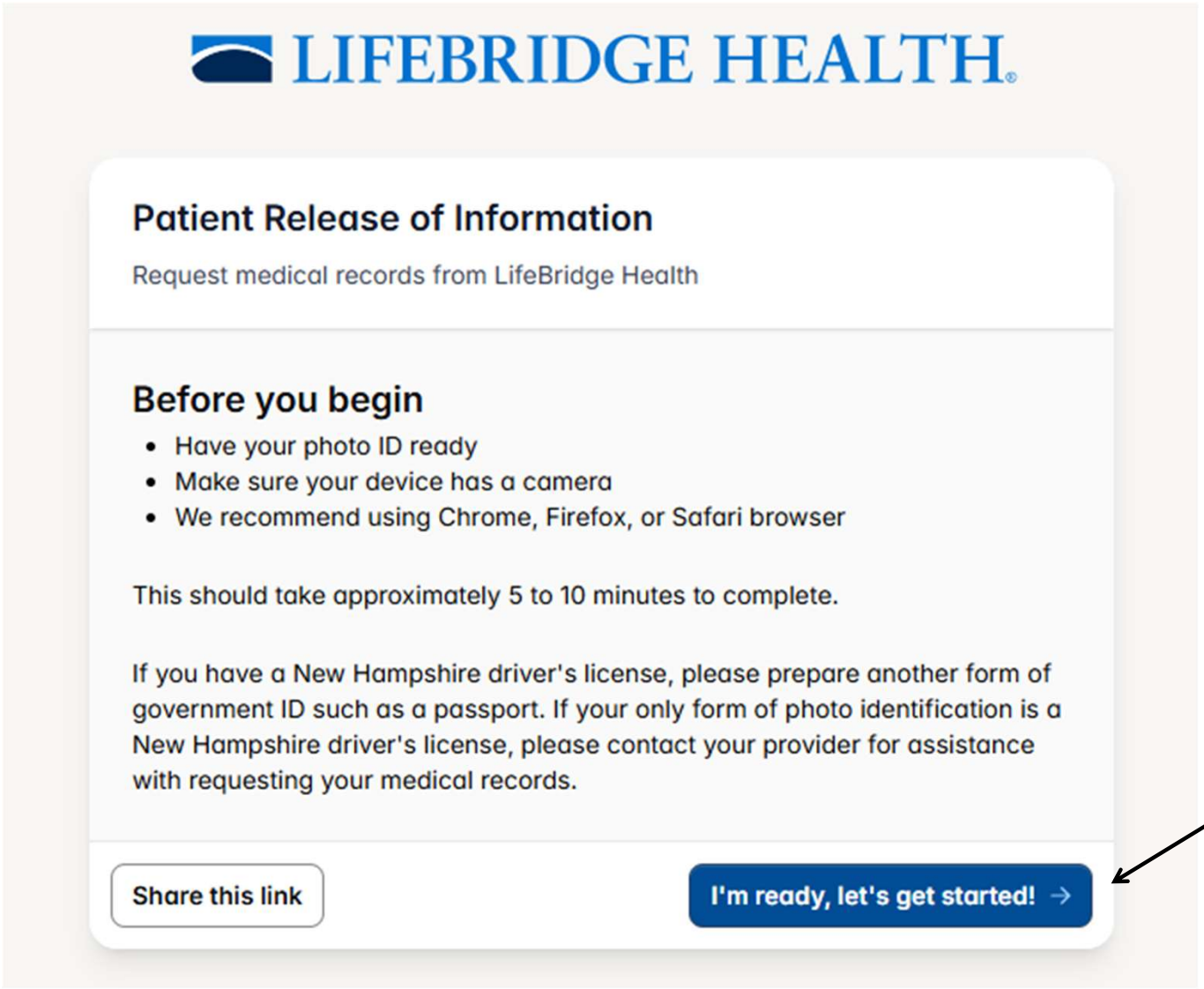
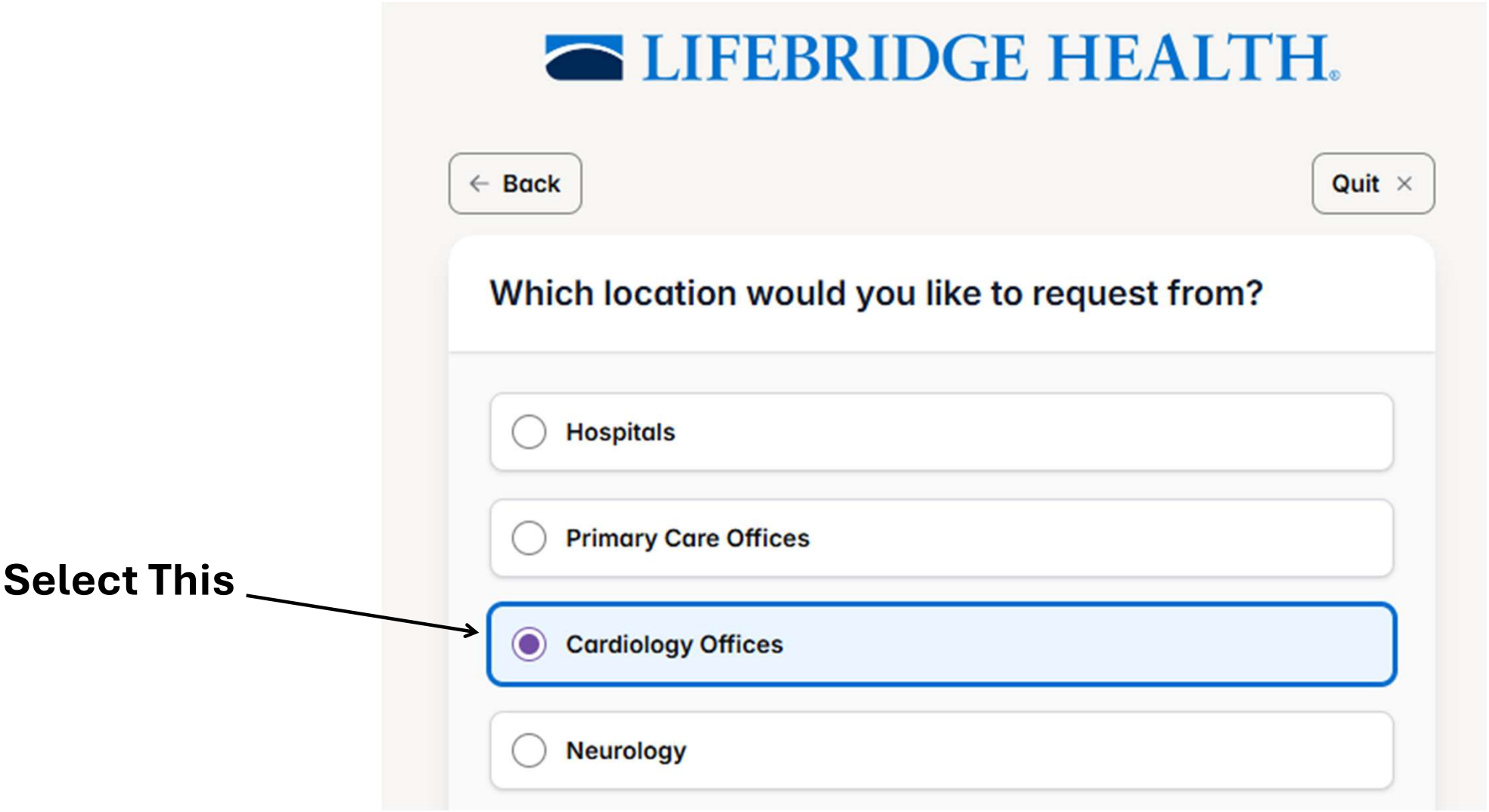
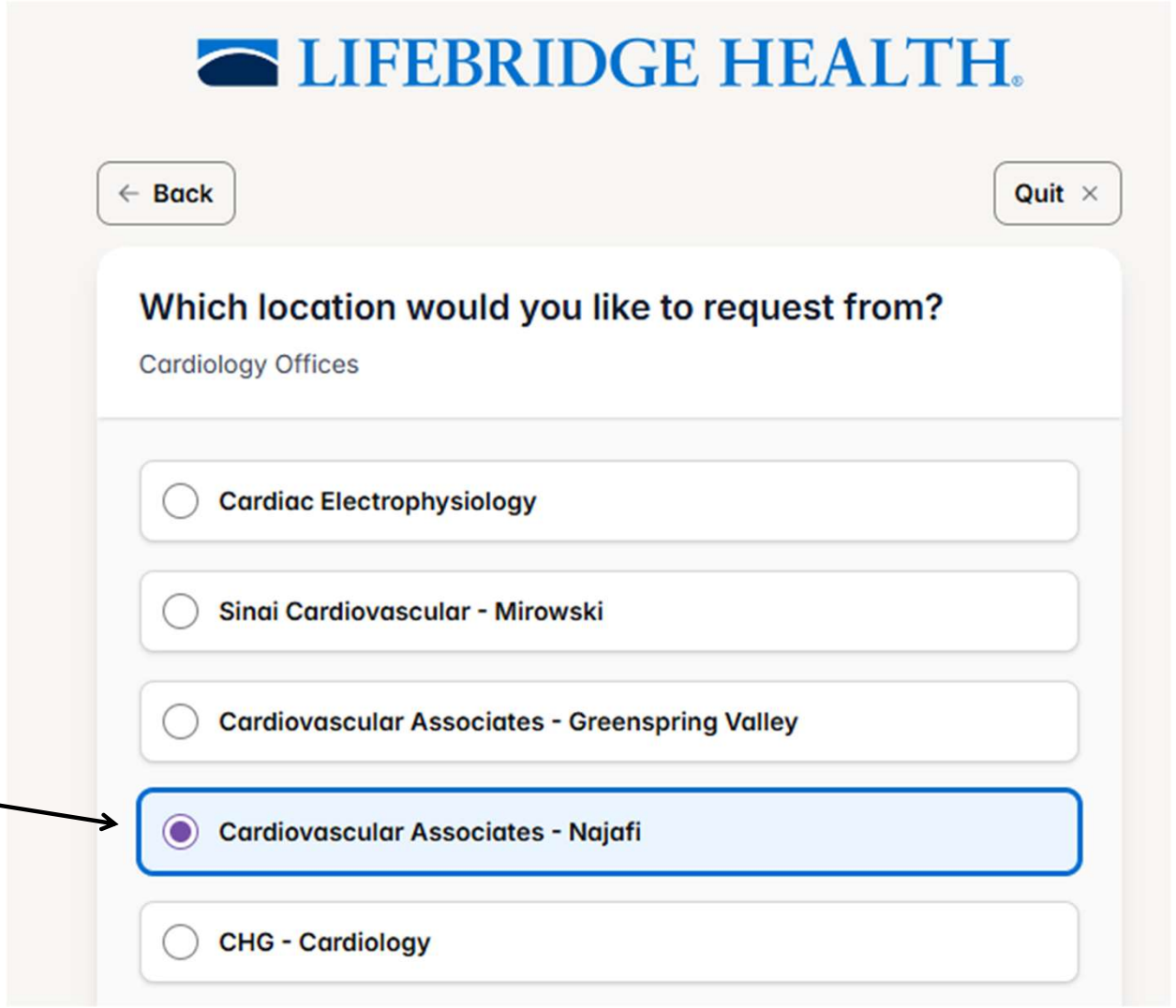

HOME
ELECTRONIC REQUEST FOR MEDICAL RECORDS
Electronic Request for Medical Records
Easily request your medical records with our online request system
Click Here to Place a Request for Medical Records

Click Here


LIFEBRIDGE HEALTH
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


LIFEBRIDGE HEALTH
Back
Quit
Which location would you like to request from?
Hospitals
Primary Care Offices
Cardiology Offices
Neurology
Select This

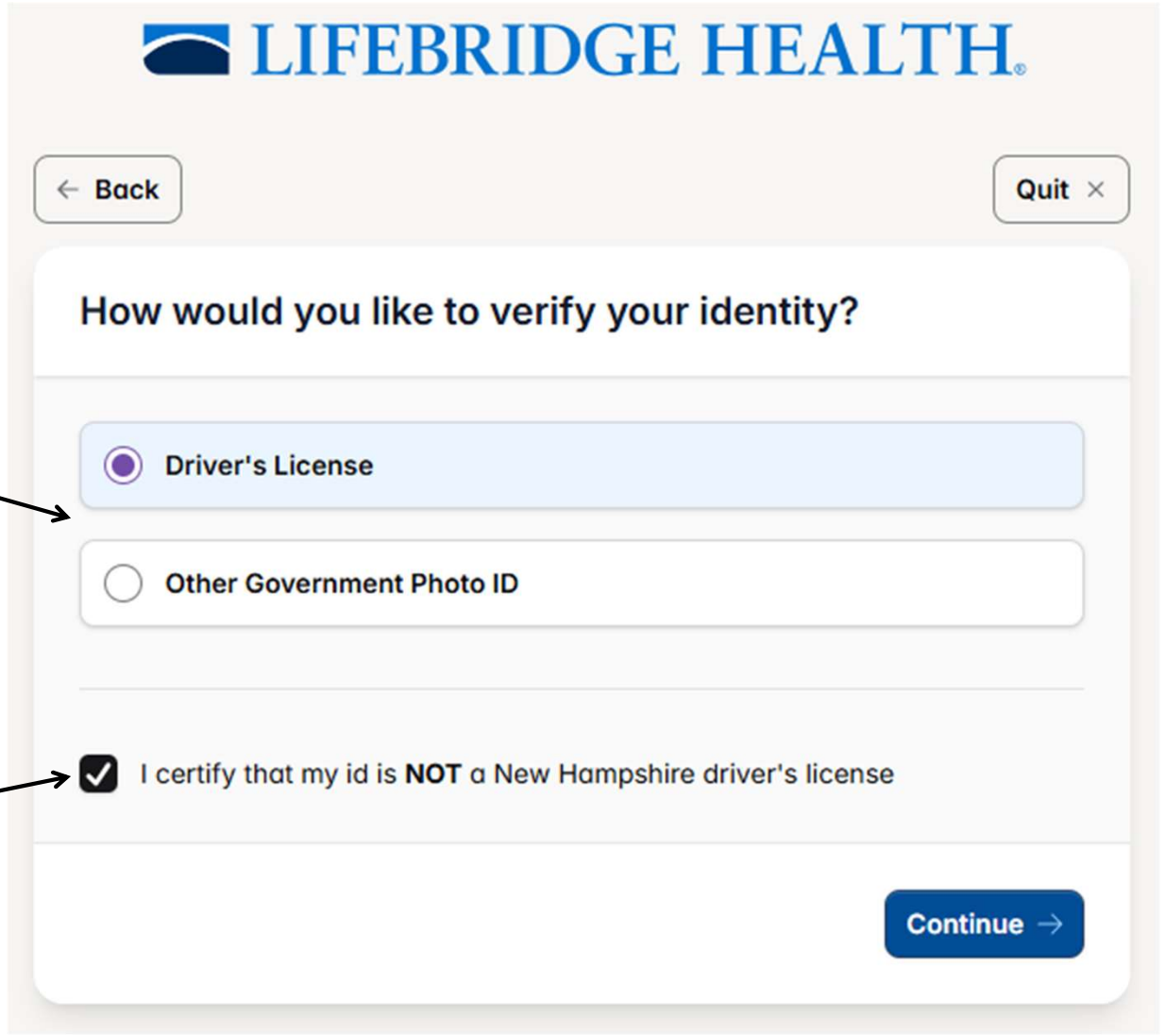
Select This

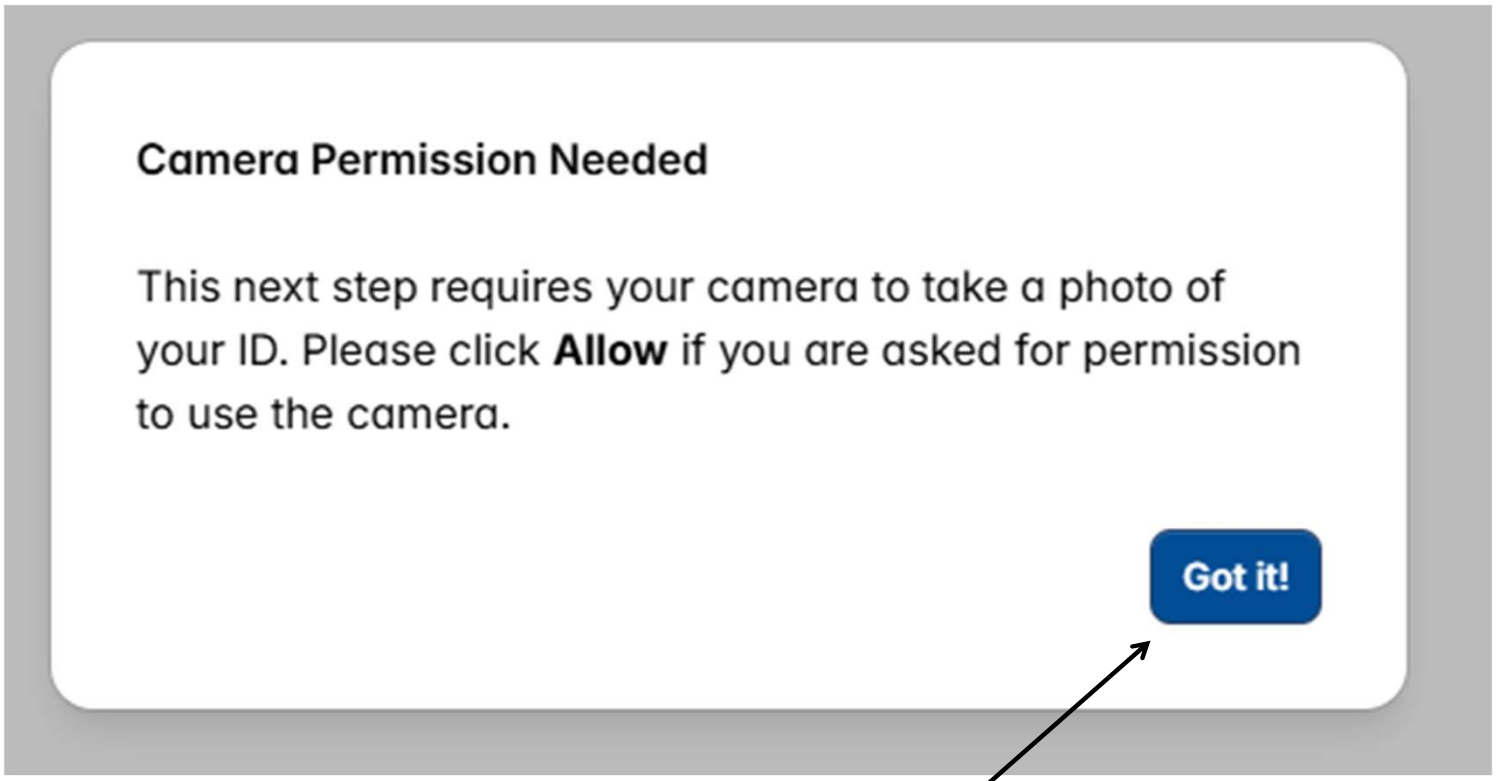

LIFEBRIDGE HEALTH
Back
Quit
Which location would you like to request from?
Cardiology Offices
Cardiac Electrophysiology
Sinai Cardiovascular - Mirowski
Cardiovascular Associates - Greenspring Valley
Cardiovascular Associates - Najafi
CHG - Cardiology

Select that you are the patient, then click continue.

First, select the form of ID that you have.

You must check this box before it lets you continue.

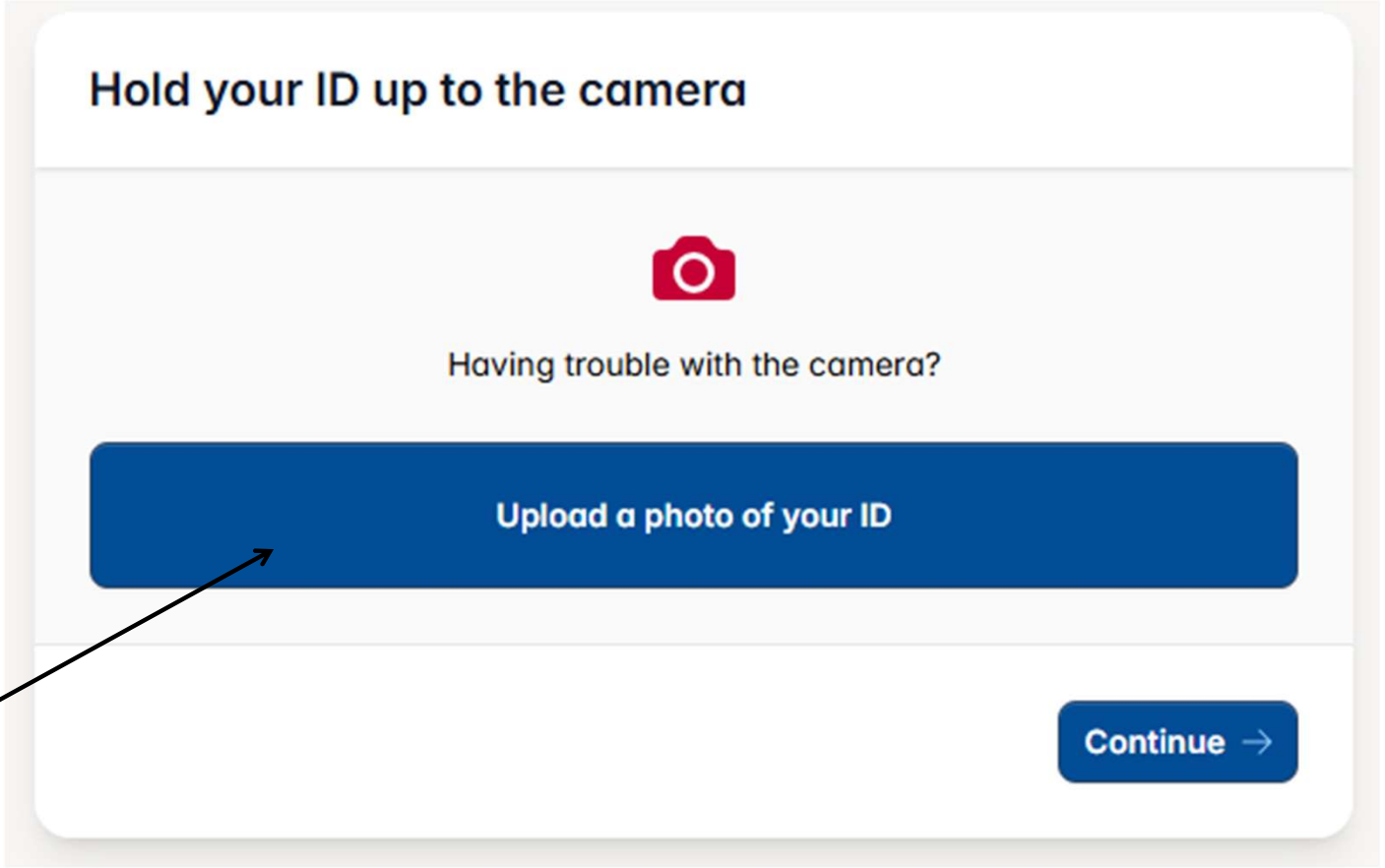




Allow access to your camera by clicking this.

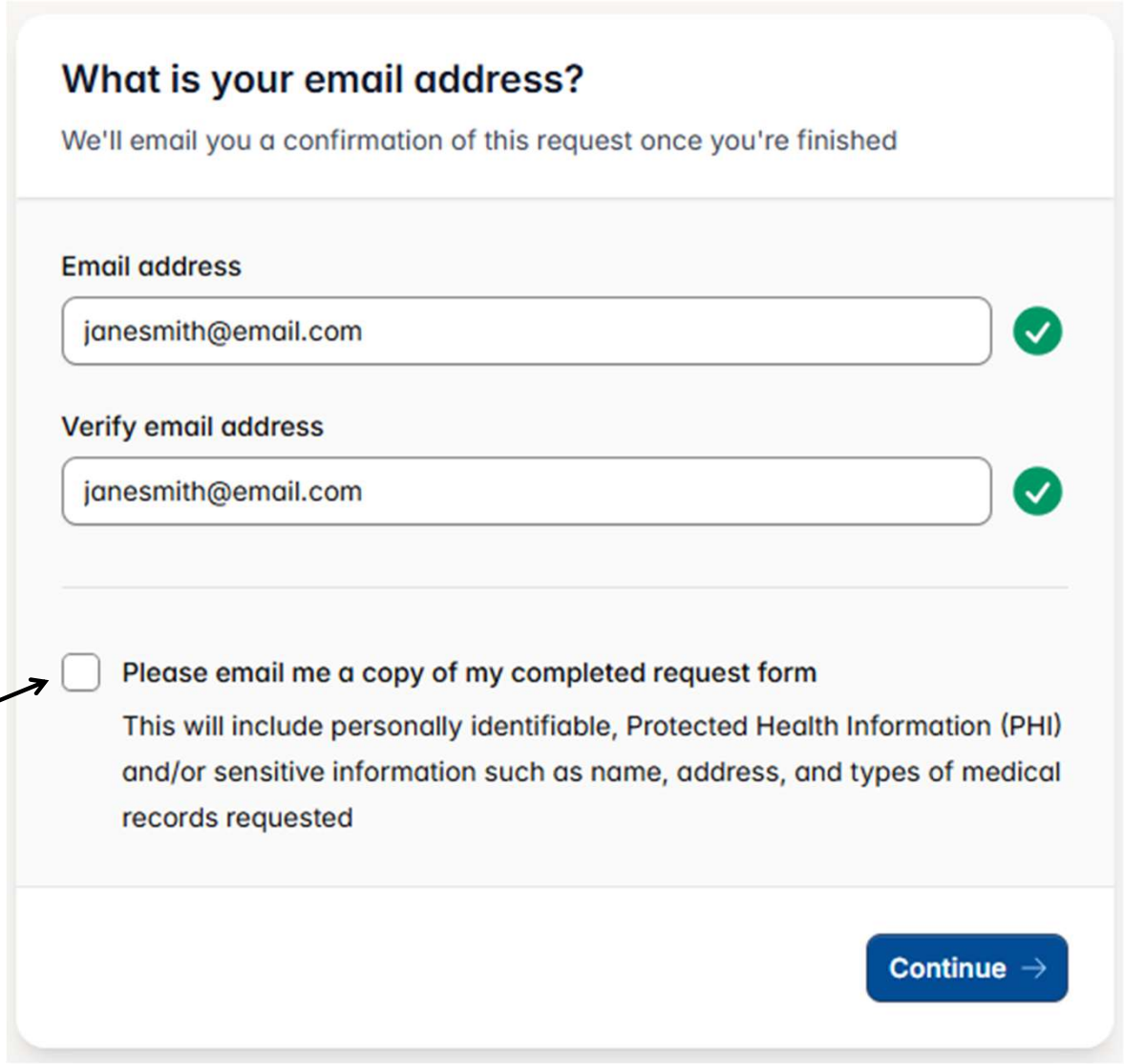
If you are using your cellphone, take a photo of your ID then click continue.

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

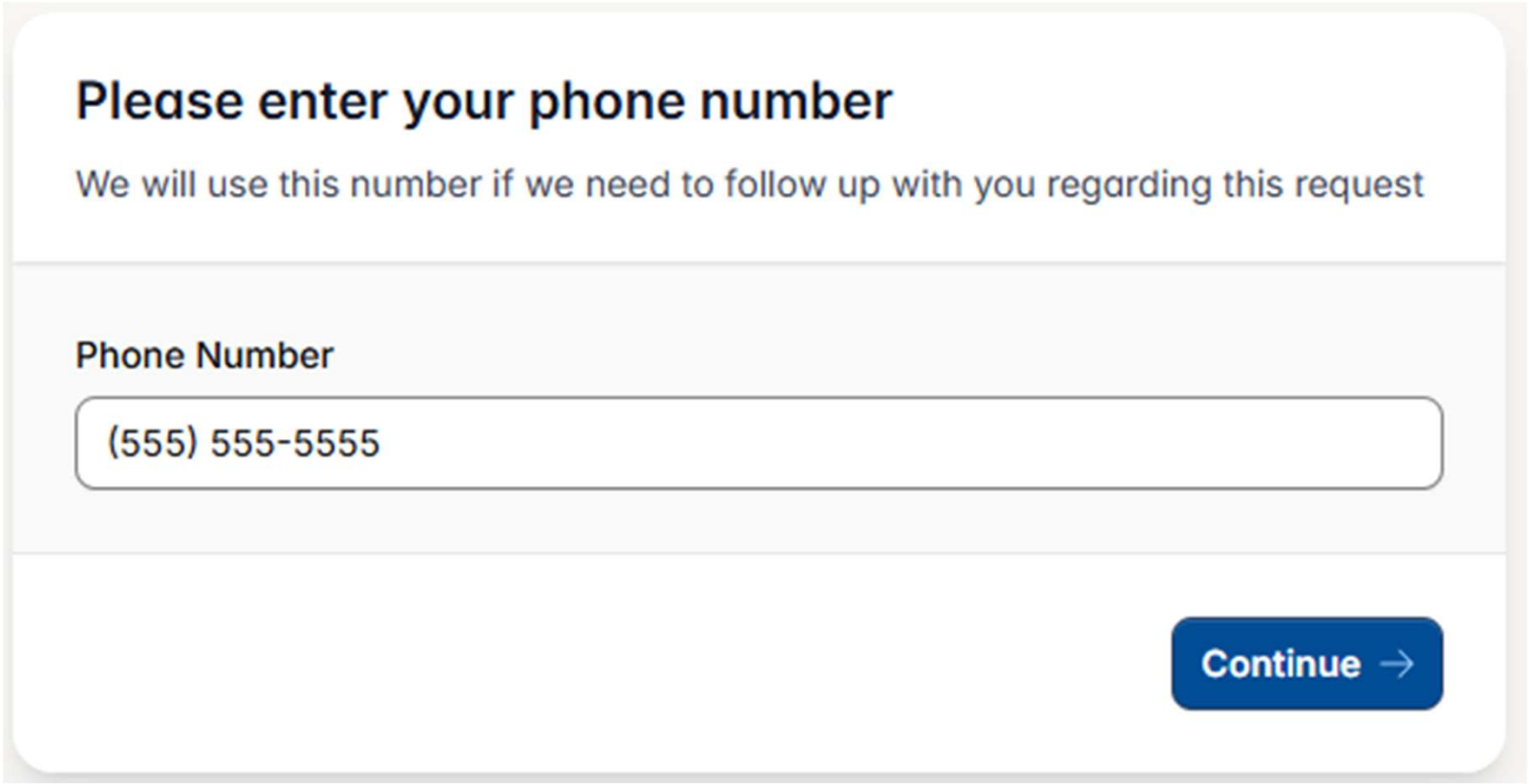


Type your email address in both boxes.

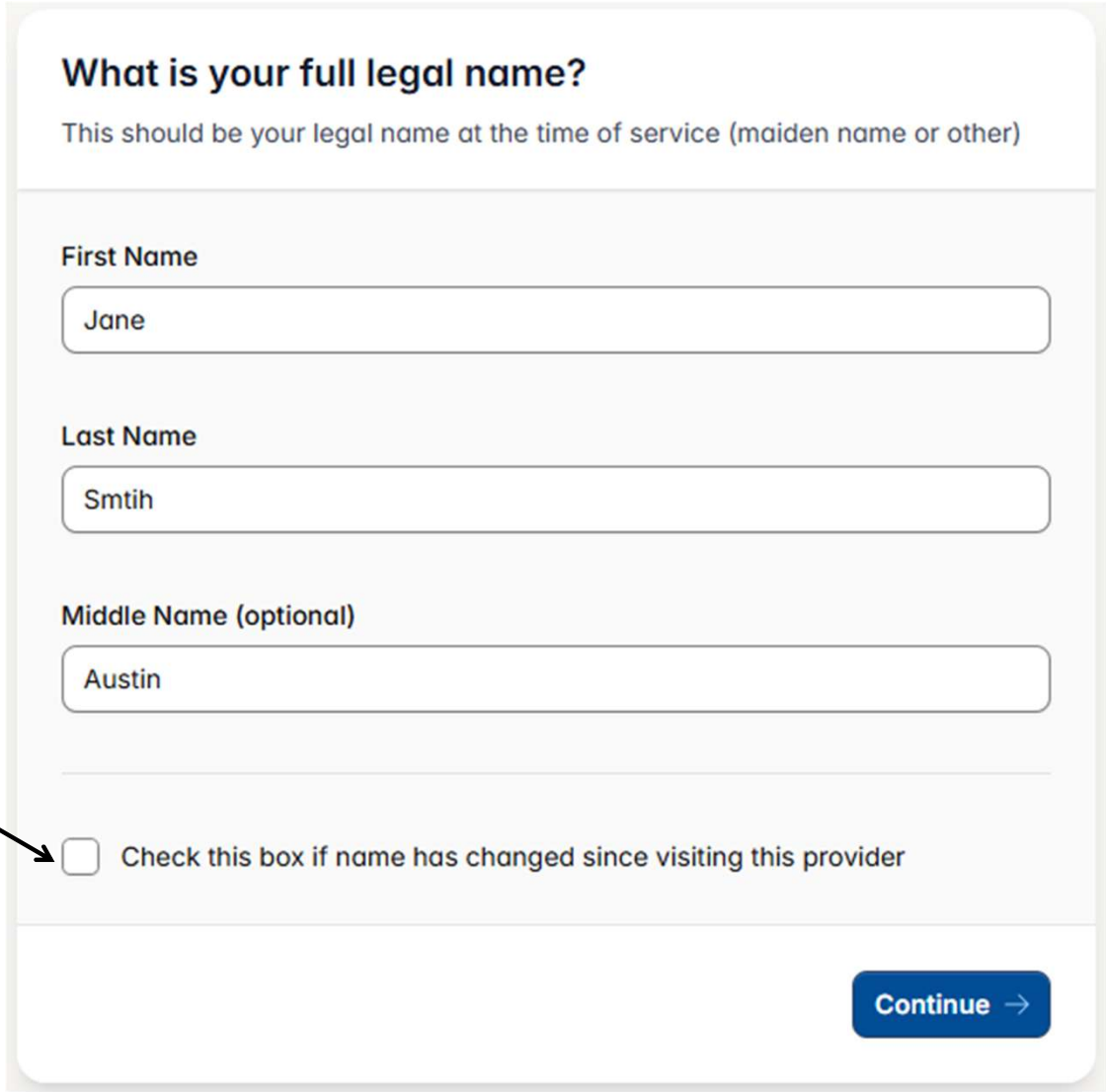
Checking this box is optional before continuing.

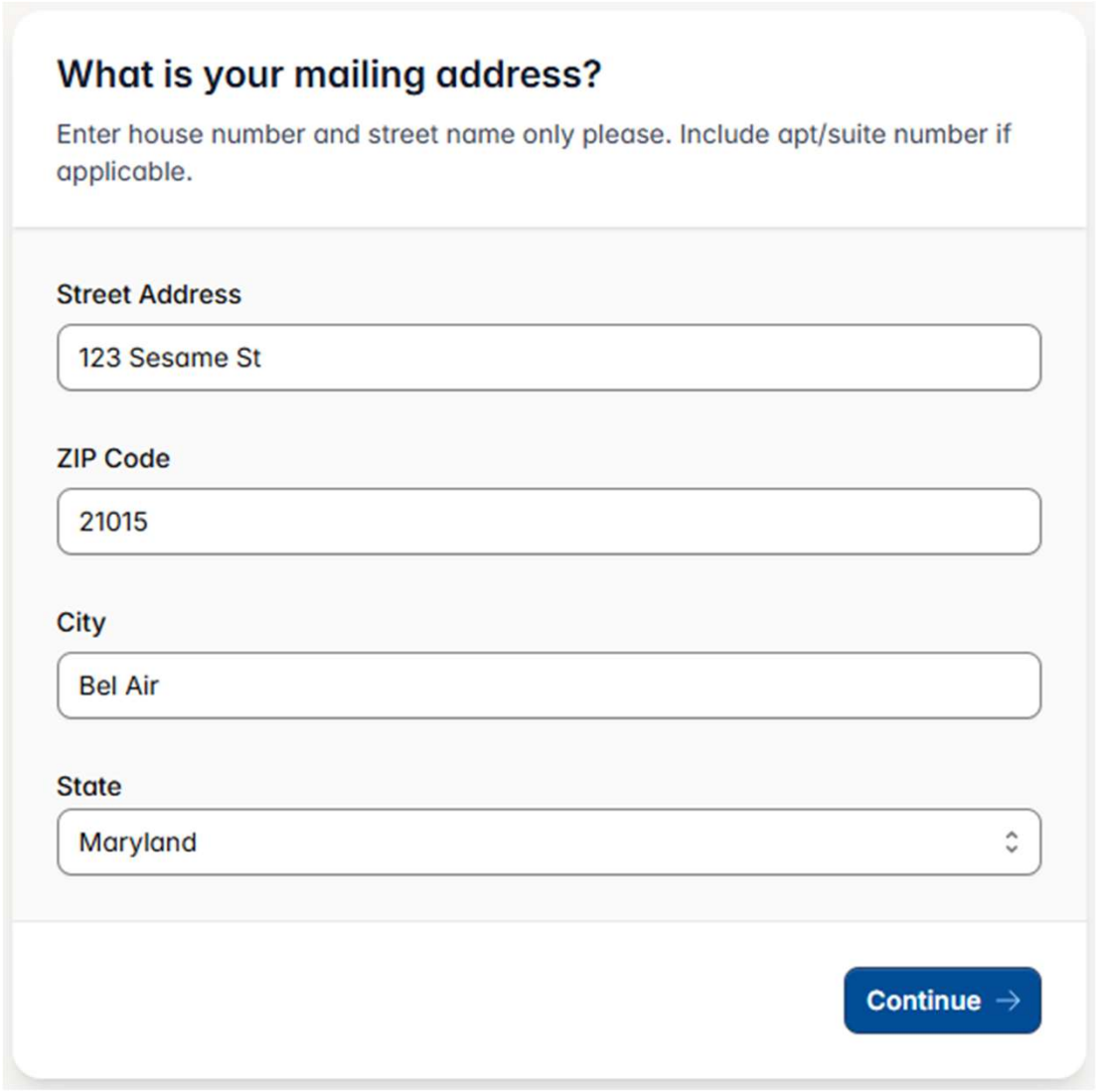


Submit your cellphone number in this step.

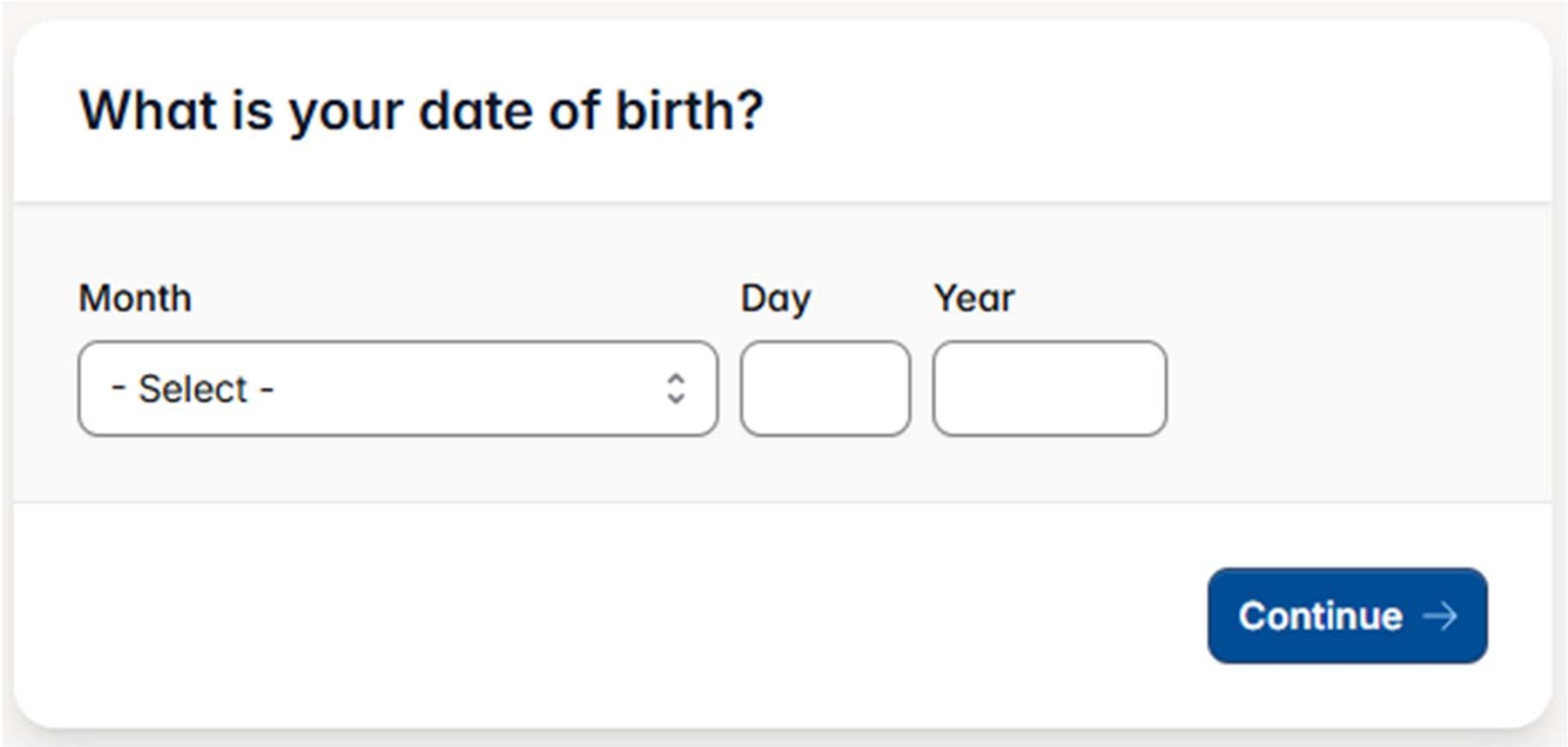


If your name has changed since your last visit at our office, click here to include the previous name that was used before continuing.





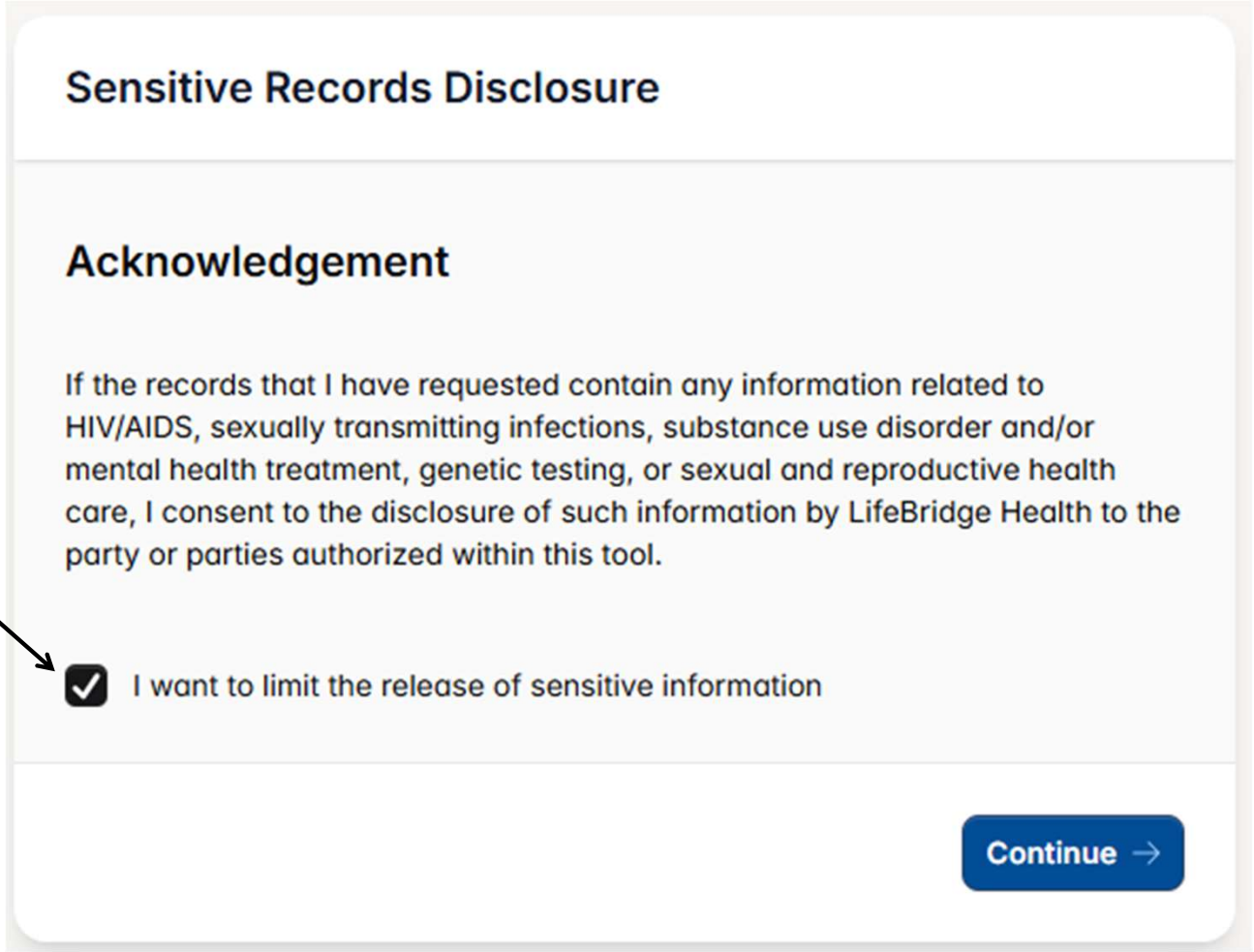
Submit your current address here before continuing.



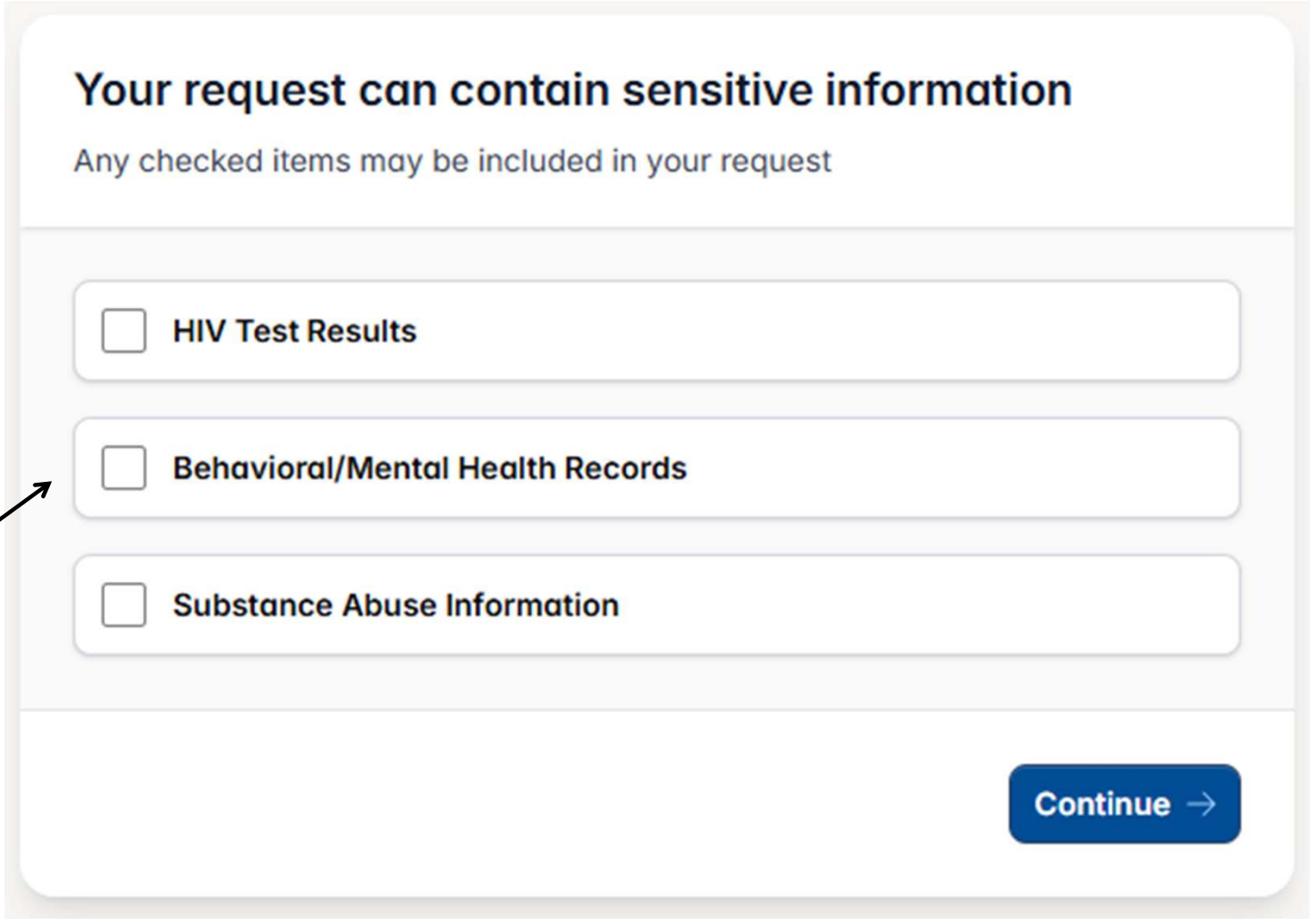
Submit your birthday before continuing.

Select this option, then continue.

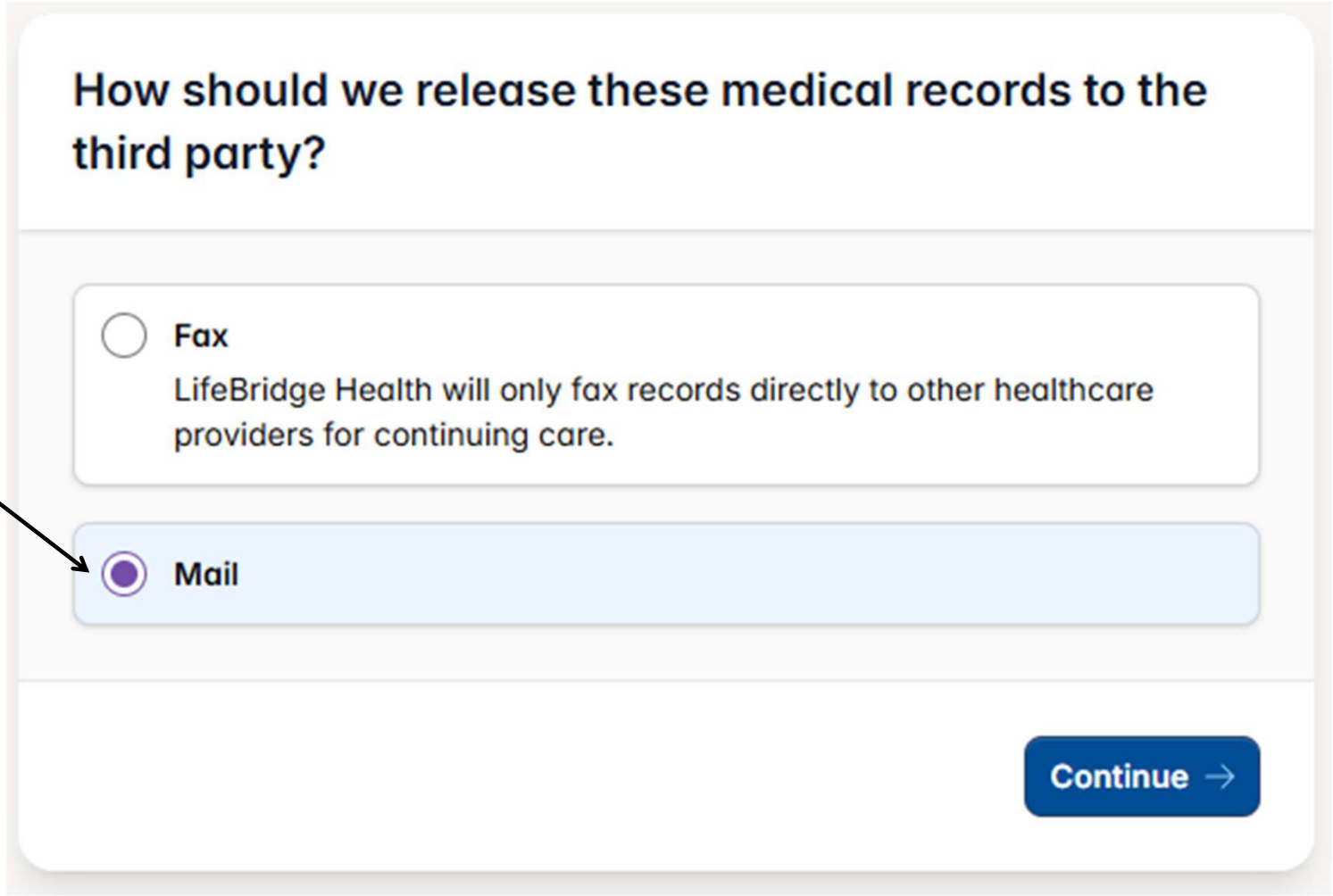
Please make sure this box is checked before continuing. We do not need these records.

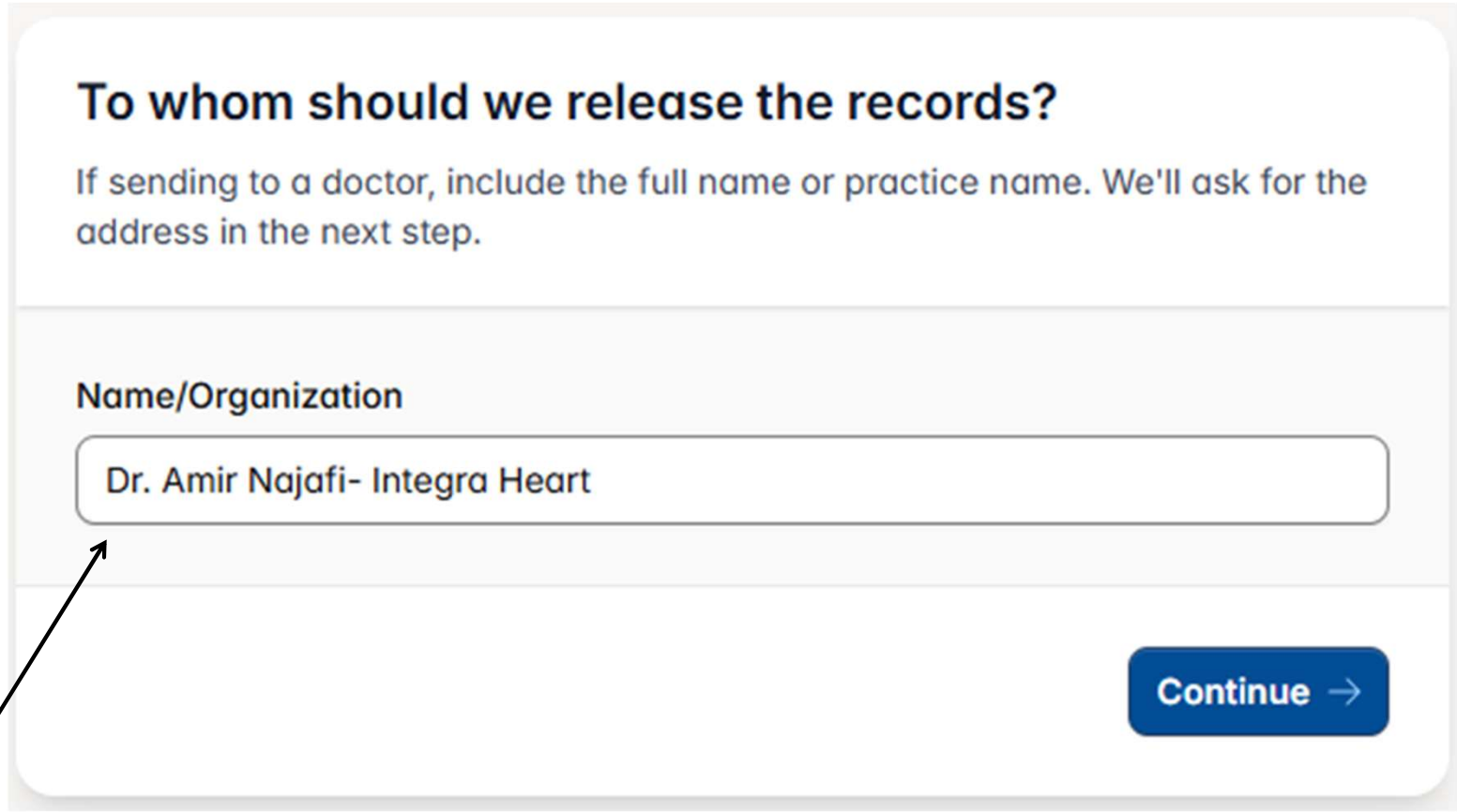


These will be automatically selected. Please unselect each box before continuing.



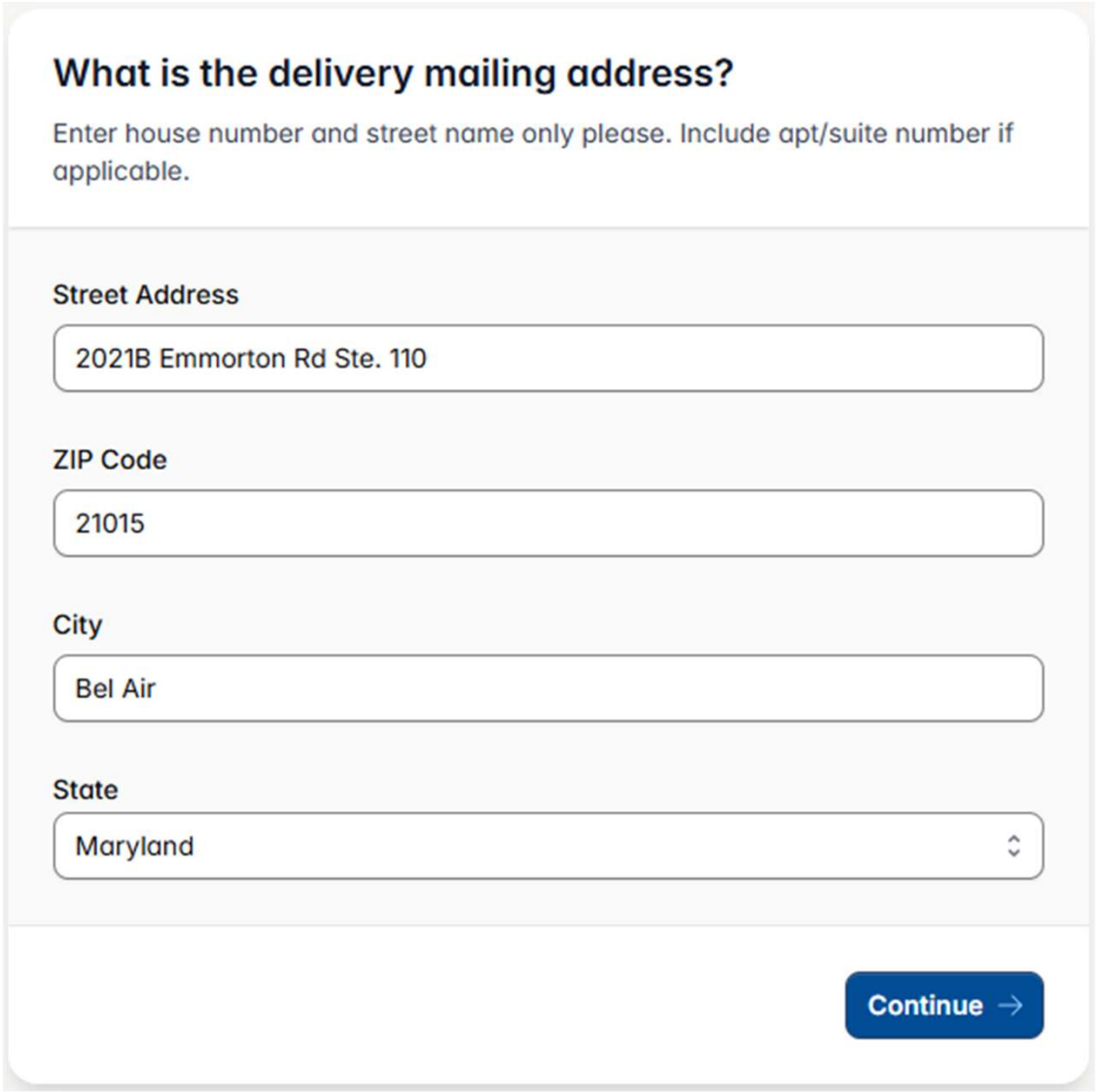
Select mail, then continue.



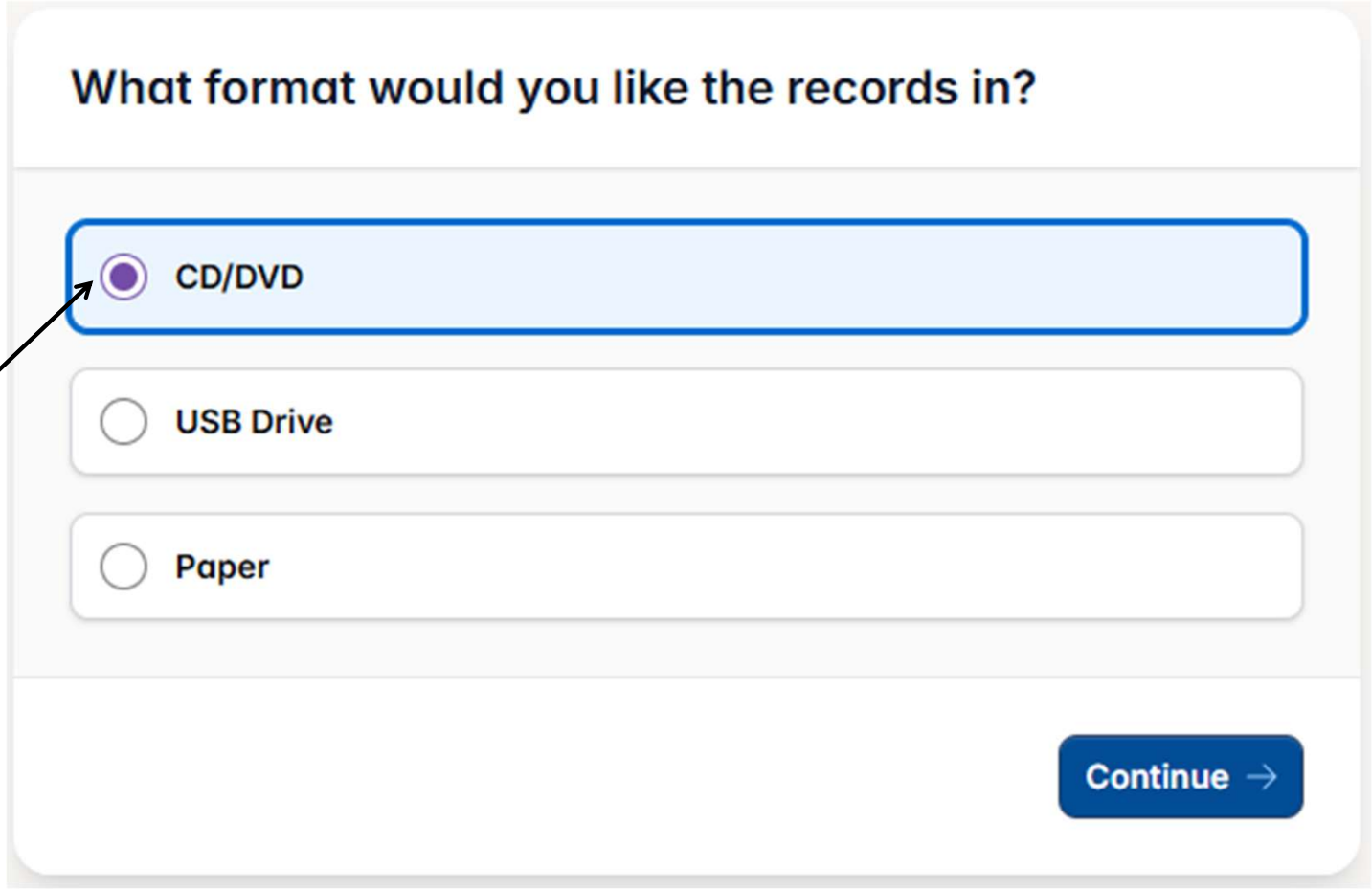


Type this in exactly as shown, then continue.

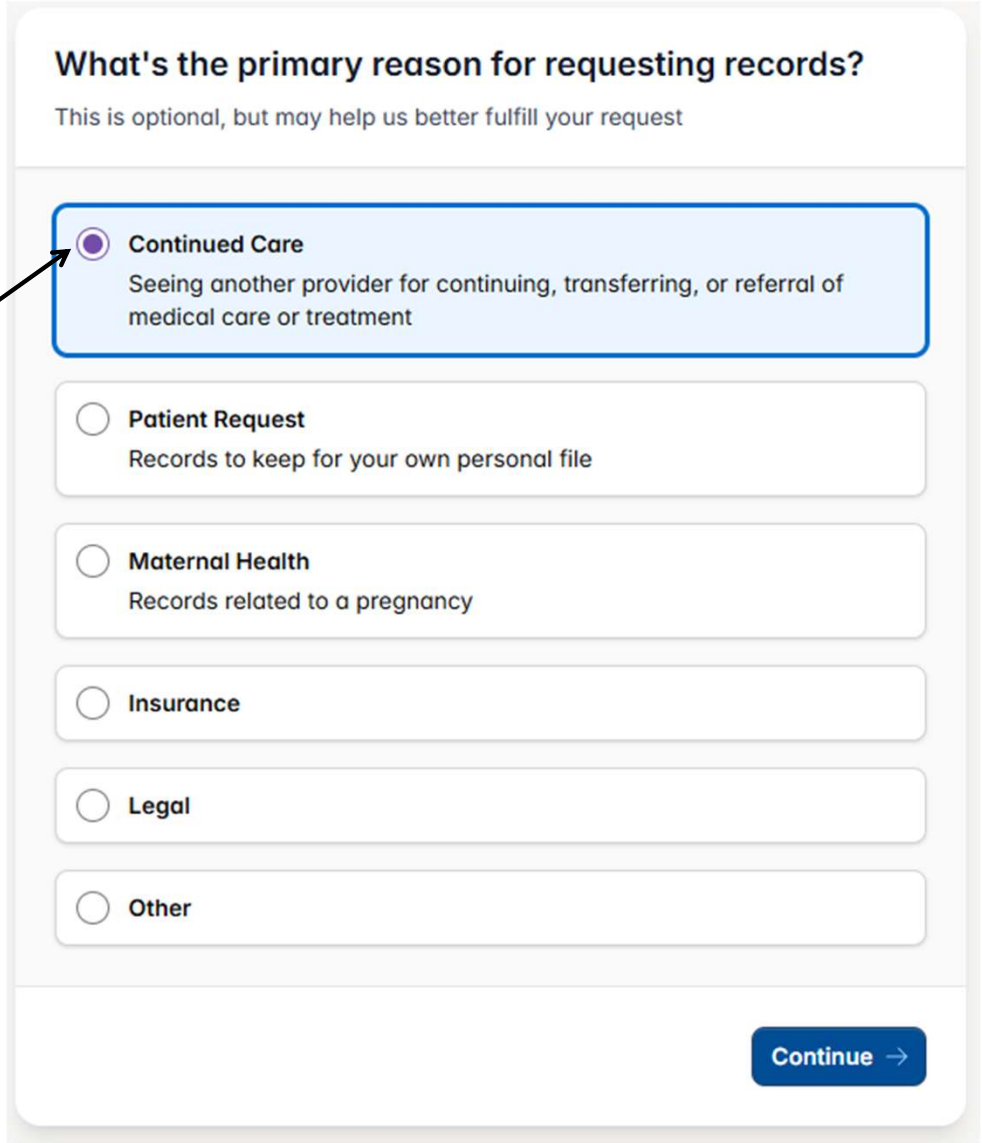
Fill in our business address as shown, then continue.



Select CD/DVD, then continue.



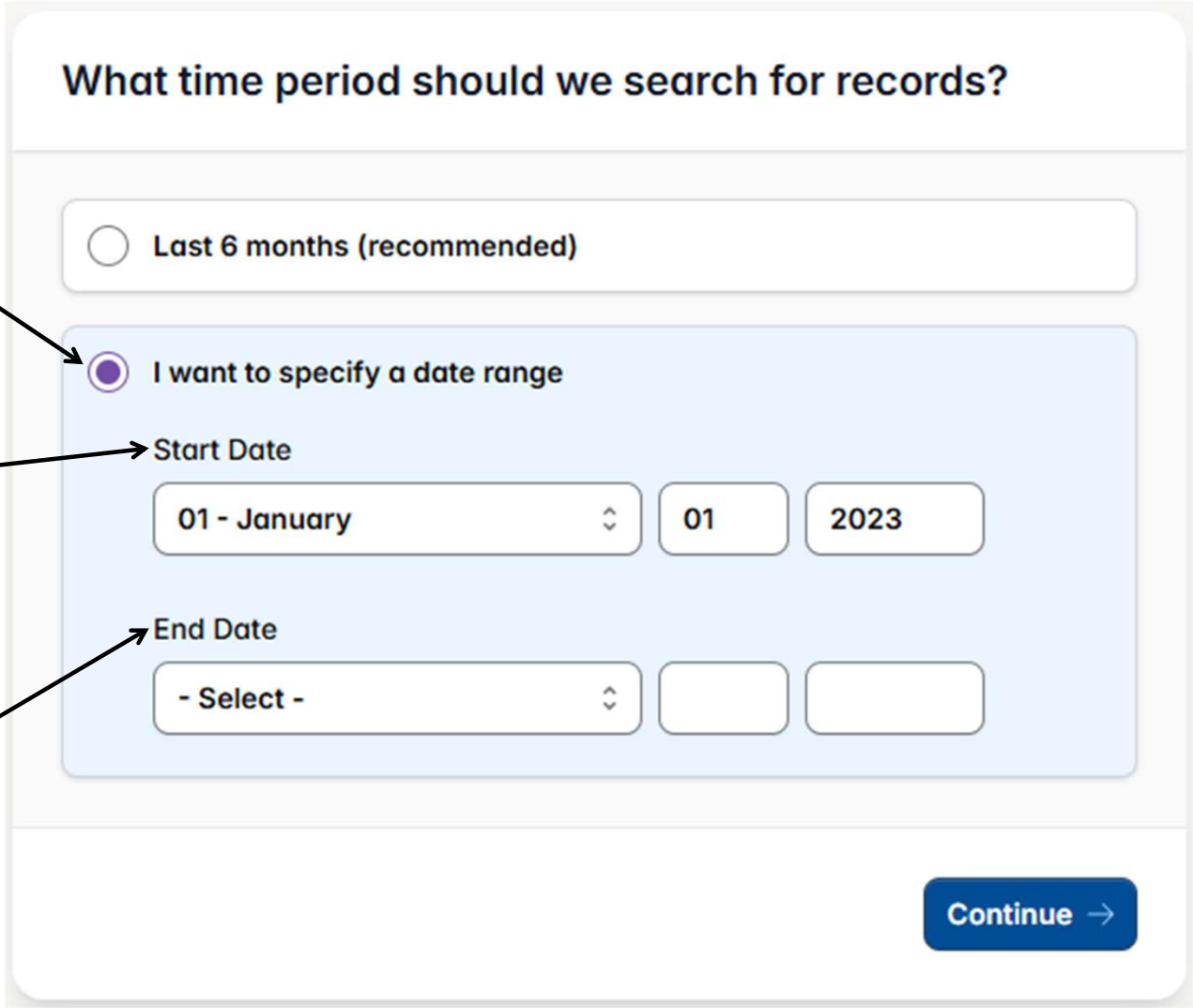
Select continued care, then continue.



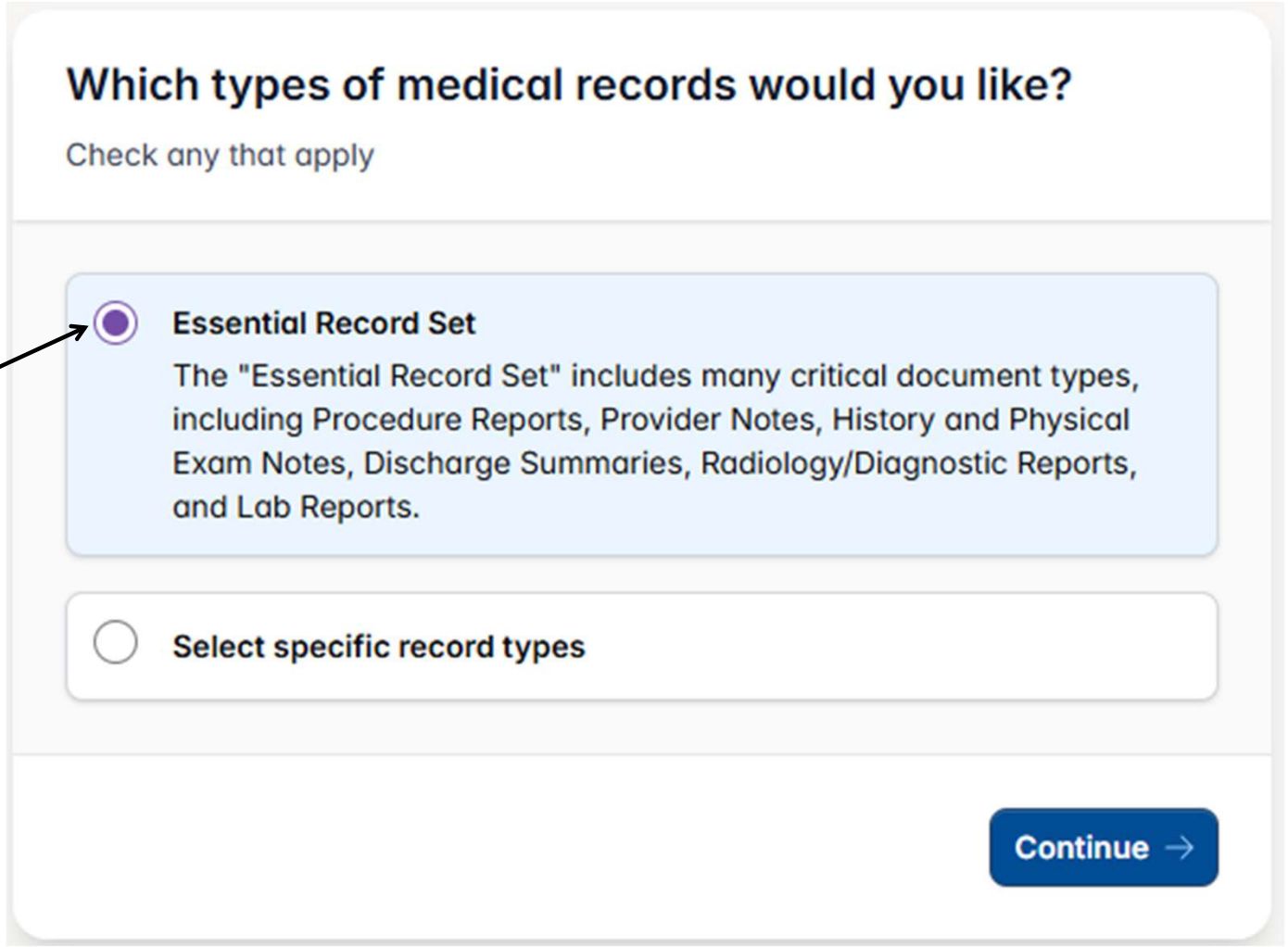
Select this option.

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

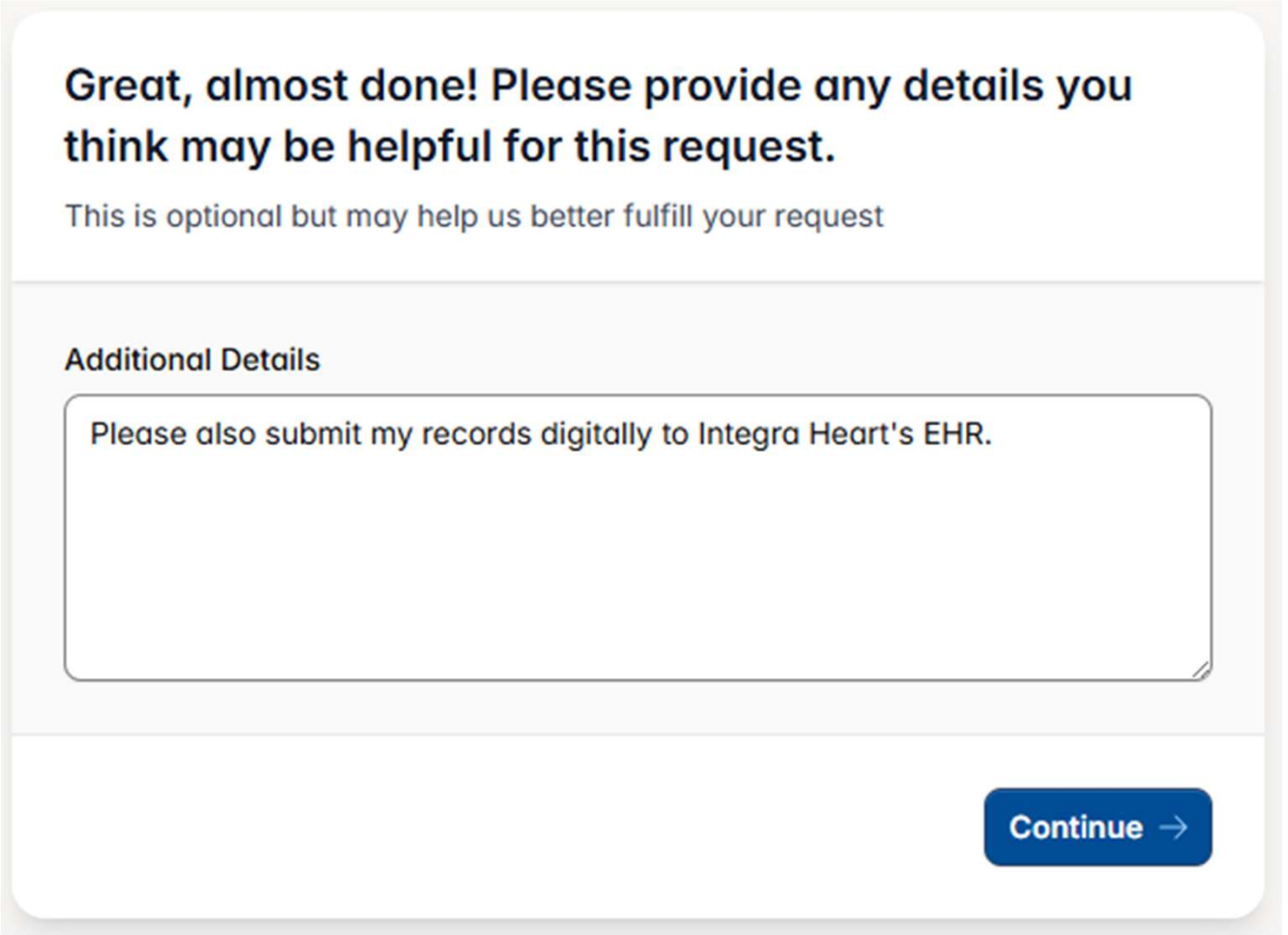
For the end date, please enter yesterday's date.



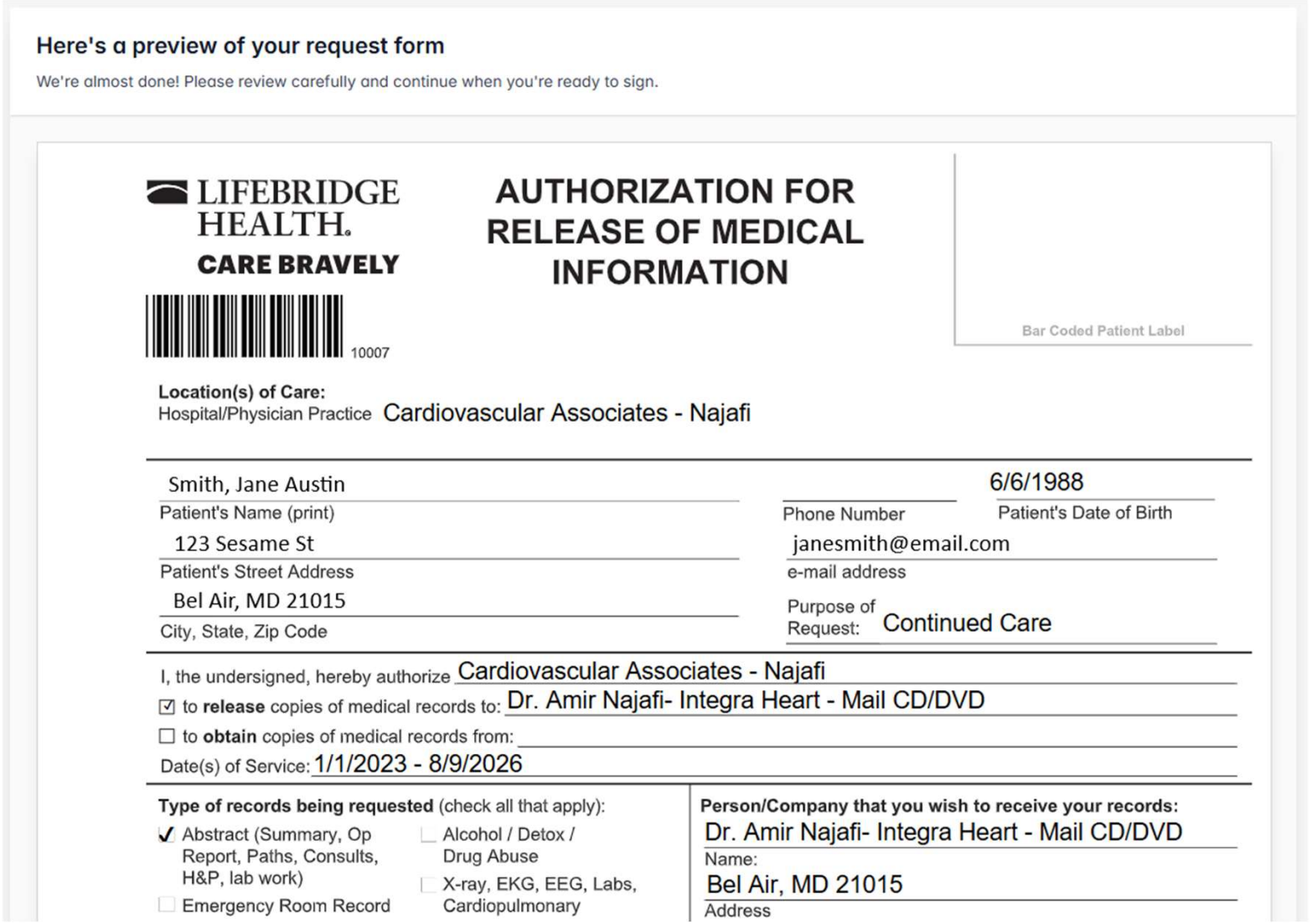
Select this option.



Please fill this section out with the following request.



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.

LIFEBRIDGE HEALTH.
CARE BRAVELY

10007

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)	Phone Number 6/6/1988 Patient's Date of Birth
123 Sesame St Patient's Street Address	janesmith@email.com e-mail address
Bel Air, MD 21015 City, State, Zip Code	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:

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

Address: Bel Air, MD 21015

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

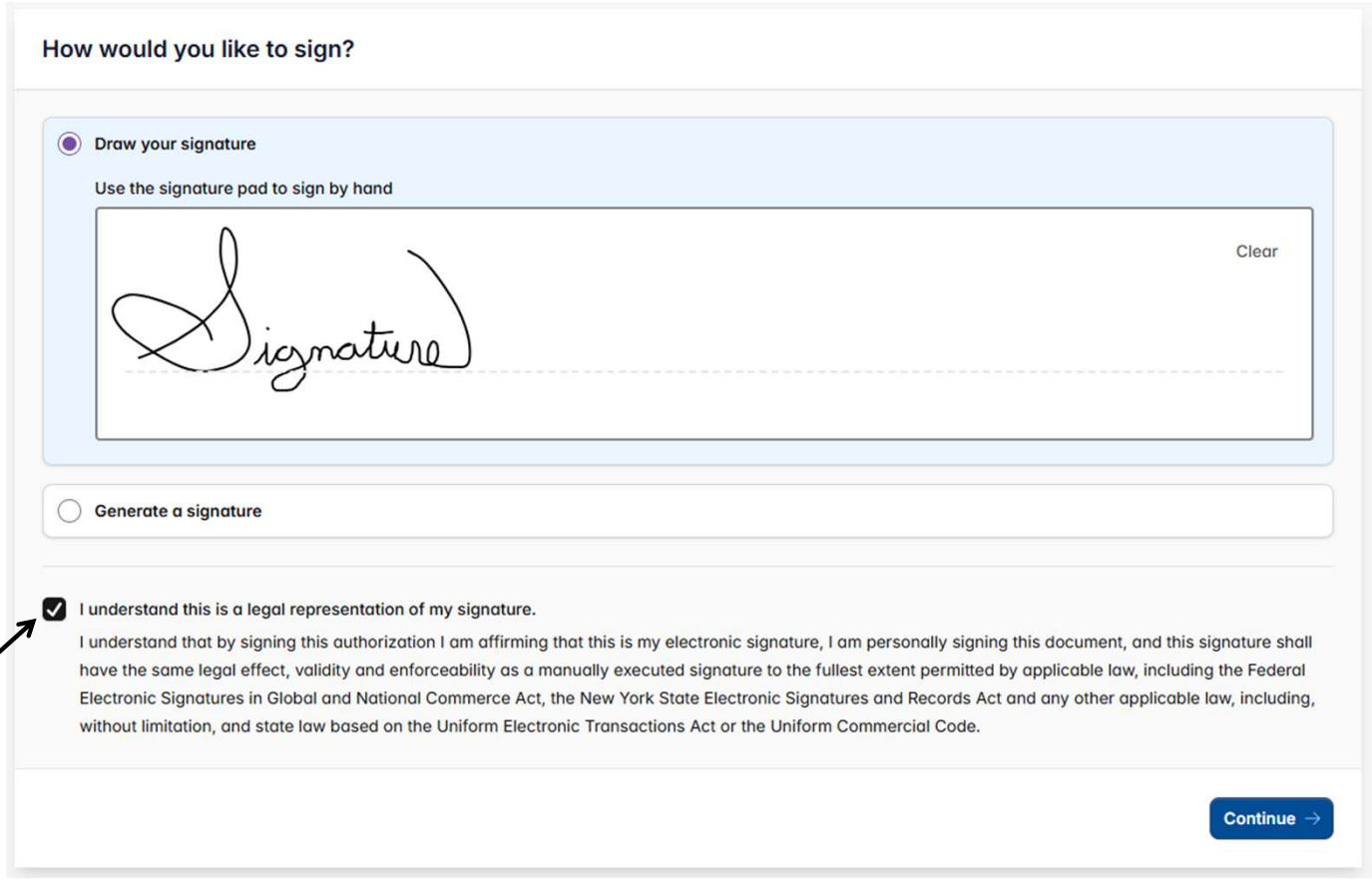
Review all of the information to confirm that your personal information is correct and confirm that our information is written correctly as shown.

If everything is correct, click continue.

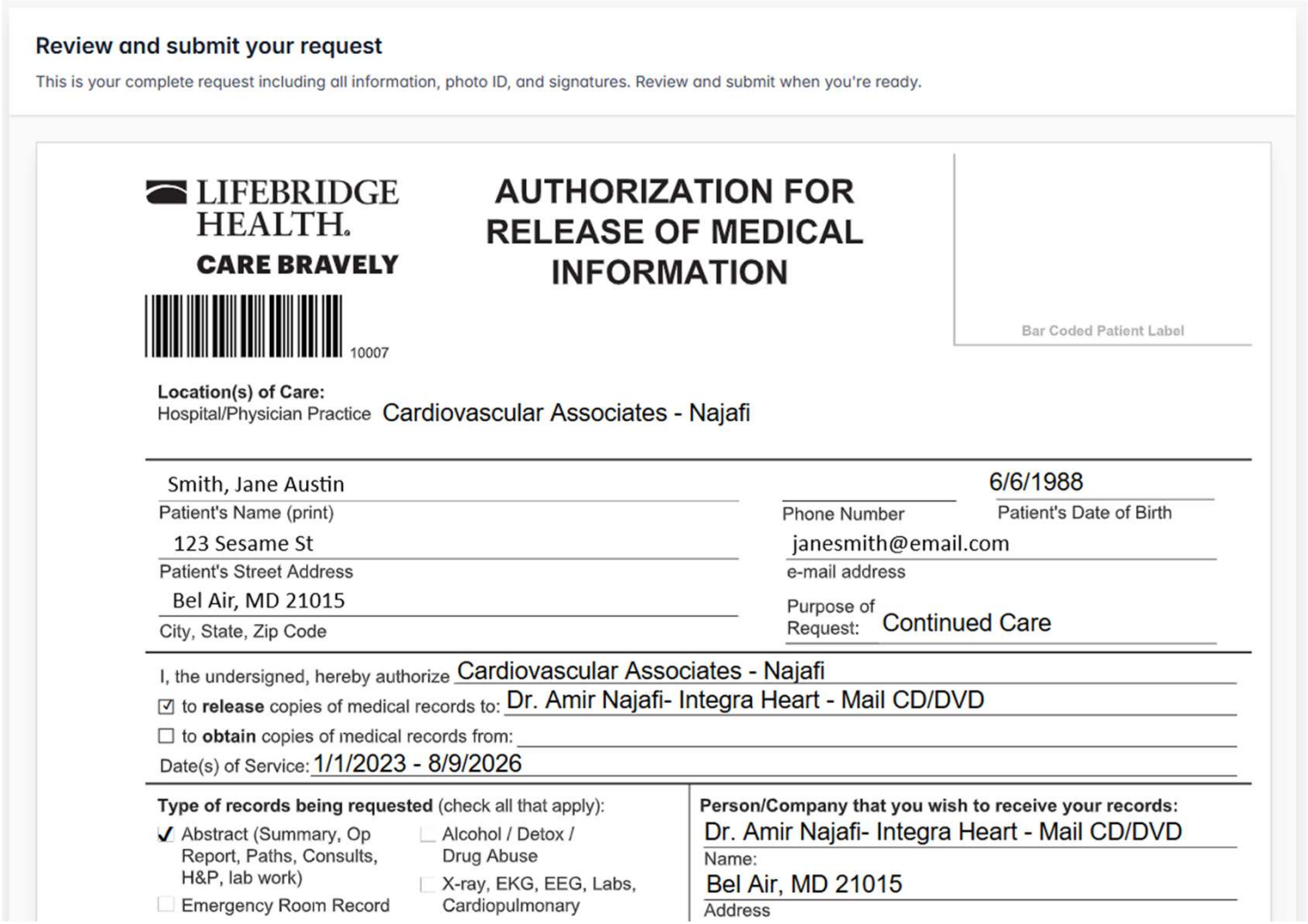
Continue →

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

Make sure this box is selected before continuing.



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

10007

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)

Phone Number

6/6/1988
Patient's Date of Birth

123 Sesame St
Patient's Street Address

janesmith@email.com
e-mail address

Bel Air, MD 21015
City, State, Zip Code

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.