

PATIENT REQUEST FOR RELEASE OF MEDICAL RECORDS INFORMATION

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Patient Identification



Patient Name:	Birth Date:	Last 4 Digits of Social Security Number
Address:		Telephone No. ()

Recipient of Information (Choose One)

Patient

Patient's Personal/Legal Representative Name: _____

*(Please provide documentation of the Personal/Legal Representative: (For example: guardianship/conservatorship, power of attorney, executor of estate)

Requested Form of Copy (Choose One)

Inspection

Paper

PDF (CD)

PDF (email)

PDF (USB drive)

Other (please specify) _____

Method of Delivery (Choose One)

Pick up/inspection (If other than patient, then specify name: _____)

Mail paper copy, CD, or USB to patient mailing address: _____

Electronic delivery (Email address: _____ or Fax # () _____ - _____)

Secure email (will require login)

Unencrypted email (by choosing this option, you accept the risk that your information could be viewed by an unauthorized person)

MyChart

Description of Requested Information:

Entire Medical Record

Abstract Medical Record (includes items with *)

Billing Information

Cardiac Studies/EKG*

Consult*

Discharge Summary*

Emergency Room*

History & Physical*

Lab*

MD Progress notes/Orders

Nursing Notes

Operative Report*

Pathology

Physician/ Clinic Office Record

Radiology

SANE Record

Substance Use Disorder

Other _____

Treatment Dates: _____

_____ Time	_____ Date	_____ Signature of Patient/ Parent/ Conservator/ Guardian	_____ Relationship to Patient
_____ Time	_____ Date	_____ Team member processing request	

- Verbal request received and identity verification completed per policy.
- Copy of Patient Release of Information form given to the patient.
- Copy of the Patient Release of Information form refused by the patient.