PATIENT REQUEST FOR RELEASE OF MEDICAL RECORDS INFORMATION

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.