C O R E S P

Patient Access Request to Their Protected Health Information

This form is for patient requests to access (view), receive or send copies of **their own medical information**.

To verify your identity and provide the correct information, please complete the below:

Patient Name _____ Date of Birth _____

Address _____ Phone number _____

City _____ State_____ Zip _____

Facilities or location from which you are requesting records. Please check as appropriate.

❑ **Bismarck Medical Center**		❑ **Garrison Memorial Hospital**	❑ **Turtle Lake Hospital**
❑ Archway Mental Health	❑ Heart & Lung Clinic	❑ Garrison Family Clinic	❑ Turtle Lake Clinic
❑ Clinics of St. Alexius	❑ Mandan Medical Plaza		❑ Washburn Family Clinic

❑ CHI Health Facility (Specify) _____

Dates of Service (please list date or date range for records requested)

From_____ To _____

Parts of the record requested:

(Below are the most frequently requested documents. This does not constitute your entire medical record, which you have the right to request.*)

Check (✓) all that apply:

❑ Abstract (Includes[1])	❑ Emergency Room Records	❑ Lab Reports
❑ Discharge Summary /Final Diagnosis[1]	❑ Immunization (shot) Record	❑ Physical Therapy Notes
❑ History and Physical Records[1]	❑ Radiology (for example: X-Ray) Reports	❑ Physician Notes
❑ Consultation Reports[1]	❑ Other Diagnostic Reports	❑ Medication List
❑ Operations and Procedures[1]	❑ Diagnostic Images (Prepped by Radiology Dept)	❑ Itemized Bill
❑ Results of Diagnostic Testing[1]	❑ Other*: _____	

I request the form of release of information be:

❑ Electronic (Portal) ❑ Paper (U.S. Mail or pick up)

❑ Electronic (Secure Email) provide email address _____

❑ Other (USB, etc. **)_____ ***Device must be provided by the facility*

continued on back

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

I will pick up the records (check here) _____
(or)
Please send the records to the person or party(ies) below at the address provided:

Recipient Name: _____

Address for receipt of record:

_____

_____

_____

_____

I understand there may be a minimal fee charged for the records.

Signature of Patient or Guardian

_____ Date_____

Print name _____

If you are the Personal Representative of the Patient:

Signature of Personal Representative _____

Authority or relationship to patient _____

(Please include copies of any documents that establish Personal Representation such as Power of Attorney document, Guardianship papers, Executor of Estate or Administrator of will documents.)