



**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 \_\_\_\_\_  
Patient Previous/Other Name(s): \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Address \_\_\_\_\_ Phone number \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Facilities or locations from which you are requesting records. Please list or circle as appropriate:**

**CHI St. Alexius Health Dickinson Hospital/Family Practice Clinic/Women’s Clinic/Beach Clinic**

**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:

- |  |  |
|--|--|
| <input type="checkbox"/> Abstract (Includes <sup>1</sup> )               | <input type="checkbox"/> Emergency Room Records                        |
| <input type="checkbox"/> Discharge Summary /Final Diagnosis <sup>1</sup> | <input type="checkbox"/> Lab Reports                                   |
| <input type="checkbox"/> History and Physical Records <sup>1</sup>       | <input type="checkbox"/> Radiology (for example: X-Ray) Reports        |
| <input type="checkbox"/> Consultation Reports <sup>1</sup>               | <input type="checkbox"/> Other Diagnostic Reports                      |
| <input type="checkbox"/> Operations and Procedures <sup>1</sup>          | <input type="checkbox"/> Diagnostic Images (Prepped by Radiology Dept) |
| <input type="checkbox"/> Results of Diagnostic Testing <sup>1</sup>      | <input type="checkbox"/> Immunization (shot) Record                    |
|  | <input type="checkbox"/> Physical Therapy Notes                        |
|  | <input type="checkbox"/> Physician Notes                               |
|  | <input type="checkbox"/> Medication List                               |
|  | <input type="checkbox"/> Itemized Bill                                 |

Other\*: \_\_\_\_\_

I request the form of release of information be:

Electronic (HIM Department Portal) \*email address required: \_\_\_\_\_



\_\_\_\_\_ Paper (U.S. Mail or pick up)      \_\_\_\_\_ Other (USB, etc...\*\*)\_\_\_\_\_

\*\*Device must be provided by the facility

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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Email Address for receipt of records:

\_\_\_\_\_

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.)