CommonSpirit

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 locations from which you are requesting records. Please list or check as appropriate:

❑ CHI St. Alexius Health Dickinson Hospital

❑ CHI St. Alexius Health Family Practice Clinic

❑ CHI St. Alexius Health Dickinson Women Clinic

❑ CHI St. Alexius Health Beach Clinic

❑ CHI Health Facility (Specify) ________________

❑ 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])

__ Discharge Summary /Final Diagnosis[1]

__ History and Physical Records[1]

__ Consultation Reports[1]

__ Operations and Procedures[1]

__ Results of Diagnostic Testing[1]

__ Emergency Room Records

__ Lab Reports

__ Radiology (for example: X-Ray) Reports

__ Other Diagnostic Reports

__ Diagnostic Images (Prepped by Radiology Dept)

__ Immunization (shot) Record

__ Physical Therapy Notes

__ Physician Notes

__ Medication List

__ Itemized Bill

__ 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

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.)