CHI St. Alexius Health

Williston Medical Center

CHI St. Alexius Health
Williston Medical Center
1301 15th Avenue West
Williston, ND 58801

Phone: 701.774.7048
Fax: 701.774.7468
CHIStAlexiusHealth.org

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.**

☐ CHI St. Alexius Health Williston Medical Center

☐ CHI Craven Hagan Clinic

☐ CHI Williston Specialty Clinic

☐ CHI Leonard P. Nelson Cancer Center

☐ CHI Health Facility (Specify) _____

☐ CHI Health Facility (Specify) _____

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 check as appropriate:

_____
_____
_____
_____

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*: _____

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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.)