PATIENT ACCESS FORM

Section A: This section must be completed for all requests for access		
Patient Last Name	**First Name**	**MI**
Date of Birth	**Social Security Number (*optional):***	
Address:		
City:	**State:**	**Zip:**
Phone Number:	**Email Address:**	
Name at time of treatment, if different than above:		
Name and address of health provider or entity who will provide you with access to this information:		
Where do you want the information sent? Self ☐ or Personal Representative (indicated below) ☐		
Personal Representative Name:		
Address:		
City:	**State:**	**Zip:**
Phone Number:	**Email Address:**	
Fax Number:		

What records are you requesting?

Description:	*Date(s):*	*Description:*	*Date(s):*	*Description:*	*Date(s):*
☐ All Protected Health Information in medical record ☐ Admission form ☐ Physician orders ☐ Medication Sheets ☐ Lab Tests		☐ Discharge Summary ☐ Progress Notes ☐ Initial Evaluation ☐ Itemized bill ☐ History and Physical exam ☐ Radiology Reports		☐ Other: ☐ Other: ☐ Other:	

Please describe the exact nature and dates of medical records that you would like.
_____

Preferred method of delivery: ☐ secure email ☐ mail ☐ pick up of paper copies ☐ fax ☐ patient portal (where available)
☐ Other electronic method (USB, CD, other). Please specify: _____

Please print your name and sign below:

_____ _____
Name of Patient or Personal Representative Relationship

_____ _____
Signature of Patient or Personal Representative Date

Select Medical recognizes a patient's rights under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.