

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:			Date of Birth (for MyChart use only):		
Address:					
City:		State:		Zip:	
Phone Number:			Email Address:		
Fax Number:					
What records are you requesting?					
<i>Description:</i>	<i>Date(s):</i>	<i>Description:</i>	<i>Date(s):</i>	<i>Description:</i>	<i>Date(s):</i>
<input type="checkbox"/> All Protected Health Information in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Physician orders <input type="checkbox"/> Medication Sheets <input type="checkbox"/> Lab Tests		<input type="checkbox"/> Discharge Summary <input type="checkbox"/> Progress Notes <input type="checkbox"/> Initial Evaluation <input type="checkbox"/> Itemized bill <input type="checkbox"/> History and Physical exam <input type="checkbox"/> Radiology Reports		<input type="checkbox"/> Other: <input type="checkbox"/> Other: <input type="checkbox"/> Other:	
Please describe the exact nature and dates of medical records that you would like. _____					
Preferred method of delivery: <input type="checkbox"/> secure email <input type="checkbox"/> mail <input type="checkbox"/> pick up of paper copies <input type="checkbox"/> fax <input type="checkbox"/> patient portal (where available) <input type="checkbox"/> 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.