Medical Record Number ____________________

Woman's Hospital Patient Request for Access to Health Information

Patient Name: ____
Last First MI

Patient Date of Birth: ____________________ Phone no.: __________(daytime)__________(evening)

Patient Address: ____

City______________________________State______________Zip Code________________

What information would you like to access?

❑ Visit Dates ❑ Immunization Record ❑ Blood Type/Lab Results ❑ Imaging Results ❑ Physical Therapy notes
❑ Operative/Procedure Report ❑ History and Physical Report ❑ Itemized Bill
❑ Other (Specify)____ ______________________________

For Substance Use Disorder or Mental Health Records, HIV/AIDS, or Genetic test results, you must specify below:

Substance Use disorder information: ❑ History & Physical ❑ Medication ❑ Demographics ❑ Diagnosis
❑ Discharge Summary and or instructions ❑ Lab Results ❑ Orders (Physician/LIP ❑ Psychiatric Evaluation
❑ Progress Notes (Physician/LIP) ❑ Treatment Plan ❑ Other:______________________________
❑ All Substance Use Disorder Treatment Records – (Includes all alcohol, drug or other substance use disorder records maintained by the provider/treatment program, relating to the patient, including all admission forms and demographic information, medication, medical history, orders, psychiatric evaluation, clinical testing and other treatment information.)

MENTAL HEALTH RECORDS: ❑ Medication List ❑ Visit Notes ❑ Consults ❑ Medical History ❑ Other____________

GENETIC TEST RESULTS – (please specify) ____

❑ ***HIV or AIDS*** test results
What are the approximate dates of service? ______________________________

What type of access would you prefer? ❑ Paper Copy ❑ CD/Flashdrive ❑ View/Inspect
❑ Other (Specify)____
Method of delivery? ❑ Pick Up ❑ Mail ❑ Other - (Specify)______________________________
Note: Some format requests may not be producible, i.e., e-mail cannot always handle the file size of requested images.

If request/consent is to send record(s) to a third party, please specify below:

Name of third party:____ Telephone #__________________

Address of third party:____

____

Note: If request is to send by unsecure e-mail, I consent to receive patient information by unencrypted e-mail. Note that there is a level of risk that any information transmitted in unencrypted e-mail could be read by a third party.

Signature of Patient (personal representative):______________________________ Date:______________

FOR OFFICE USE ONLY:

Date Patient Access Request form received ______________