Medical Record Number ____________________

Woman's Hospital Patient Request for Access to Health Information

Please send back with a copy of your picture ID
Fax #(225)231-5473

Patient's Name	Last	First	MI
Patient's Date of Birth			
Patient's Address			
	City	State	Zip Code
Telephone No.	Daytime	Evening	

What information would you like to access?

- ❑ Immunization Record
- ❑ Blood Type Lab Results
- ❑ Imaging Results
- ❑ Operative/Procedure Report
- ❑ Other ____________________

What are the approximate dates of service? ____________________

What type of access would you prefer?

- ❑ Paper Copy
- ❑ CD
- ❑ View/Inspect
- ❑ Other - (Specify) ____________________

Method of delivery?

- ❑ Pick Up
- ❑ Mail
- ❑ Other - (Specify) ____________________

NOTE: Some formats requested may not be readily producible by Woman's Hospital, for example, e-mail cannot always accommodate the file size of requested images.

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

Name of third party: ____________________ Telephone No. ____________________

Address of third party: ____________________

____

NOTE: If request is to send by unsecure, unencrypted e-mail, I acknowledge and accept the risk that information transmitted in unencrypted e-mail could be read by a third party.

Signature of Patient (personal representative): ____________________

Date: ____________________

FOR OFFICE USE ONLY:
Date copy of Patient Request for Access form given to patient ____________________
Date copy of Patient Request for Access form mailed to patient ____________________
Date records sent ____________________
Media of records disclosed (other than paper): ❑ CD ❑ Film ❑ Other ____________________