# PATIENT REQUEST TO ACCESS HEALTH INFORMATION

MR# _____ Date/Time Received: _____

This form is ONLY used for patients (legal representatives) requesting their own health information

**Patient Name:** _____ **DOB:** _____

**Address:** _____ **Telephone #:** _____

**From what location(s):**

- ❑ HSHS St. Clare Memorial Hospital − Oconto Falls
- ❑ HSHS St. Mary's Hospital Medical Center − Green Bay
- ❑ HSHS St. Nicolas Hospital − Sheboygan
- ❑ HSHS St. Vincent Hospital − Green Bay
- ❑ HSHS Sacred Heart Hospital − Eau Claire
- ❑ HSHS St. Joseph's Hospital − Chippewa Falls
- ❑ My Chart

**From date(s) of service: _ _ /_ _ /_ _ to _ _ /_ _ /_ _ OR** _____

**Type of Information:**

- ❑ Abstract of record/Pertinent records
- ❑ Emergency Department report
- ❑ Radiology/Imaging reports
- ❑ Radiology/Imaging films/CD
- ❑ History & physical
- ❑ Consultation reports
- ❑ Laboratory/Pathology
- ❑ Progress notes_____
- ❑ Discharge summary
- ❑ Operative reports
- ❑ EKG
- ❑ Billing records _____

Or description of records and/or information as follows: _____

**Form of Information:**

- ❑ Viewing −An appointment must be scheduled with our Release of Information Specialist. Please call: 920−433−8172
- ❑ Summary −You may request a summary of certain information instead of actual copies of records/information (for example, listing of all dates of service). There may be a charge for the costs associated with preparing the summary. You will be informed of the charges prior to processing the request.
- ❑ Paper Copy of Record. There may be a charge for the costs associated. You will be informed of these charges prior to processing the request.
- ❑ Electronic Copy of Records − MyChart, Email, CD, Portal, Other −Please specify: _____

**Method of Delivery:**

- ❑ Pick up/take along in person
- ❑ Mail to address above
- ❑ Fax #: _____ By providing fax # I release the hospital from all liability for faxing my confidential information to this number.
- ❑ Email to: _____ *If the email address is shared with another person or the email password is known to others, consider other methods of delivery*. We will automatically send e−mail through encrypted/secured means unless otherwise directed. Unencrypted e−mail poses some level of risk, e.g., a third party could see the information without consent. We are not responsible for unauthorized access to unencrypted e−mail containing confidential information or any risk (e.g., virus) potentially introduced to the computer/device utilized when receiving/viewing confidential information in unencrypted electronic format or e−mail. By selecting the unencrypted e−mail option I acknowledge the risks have been communicated and I accept these risks. ❑ Unencrypted Email

_____ _____ _____

Date Time SIGNATURE **by** Patient or Legal Representative

_____ _____

OR document verbal request from Patient/Legal Representative Name Received by (Colleague Name)

If by a Legal Representative, complete the following:

1) Individual is: ❑ a minor (AODA exception) ❑ legally incompetent or incapacitated ❑ deceased
2) Legal authority: ❑ parent ❑ legal guardian ❑ activated POA for Health Care ❑ next of kin/executor of deceased

**OFFICE USE ONLY:** Signature verified or patient verified: ❑ Yes ❑ No **Date/Time Released:**_____ **Completed by:**_____

Original: Medical Record Copy: Patient A photocopy of this authorization will have the same force and effect as the original