HSHS St. Vincent St. Mary's St. Nicholas St. Clare | PREVEA health

MR# _____

Date/Time Received: _____

PATIENT REQUEST TO ACCESS HEALTH INFORMATION

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

Patient Name: _____ **DOB:** _____

Address: _____ **Telephone #:** _____

From what location(s):

☐ St. Vincent Hospital ☐ St. Mary's Hospital ☐ St. Nicholas Hospital ☐ St. Clare Memorial Hospital ☐ Prevea Health

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

Type of Information:

☐ Abstract of record/Pertinent records	☐ History & physical	☐ Discharge summary
☐ Emergency Department report	☐ Consultation reports	☐ Operative reports
☐ Radiology/Imaging reports	☐ Laboratory/Pathology	☐ EKG
☐ Radiology/Imaging films/CD	☐ Progress notes _____	☐ 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 (Hospital) (920) 433-8172
(Prevea) (920) 496-4737

☐ Summary - You may request a summary of certain information instead of actual copies of records/information (for example, listing of all dates of service).

☐ Paper Copy of Record

☐ Electronic Copy of Records – Email, CD, Portal, Other – Please specify: _____

Summary or Copy Requests: There may be a charge for the costs associated with preparing the summary or producing copies. You will be informed of these charges prior to processing the request.

Method of Delivery:

RI

☐ Pick up/take along in person

☐ Mailed 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 e-email address is shared with another person or the e-mail password is known to others, consider other methods of delivery*. We will automatically send e-mail through encrypted/secured means unless otherwise directed. Unencrypted email 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 email 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

_____ _____

SIGNATURE by Patient or Legal Representative **Date**

_____ _____

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