



Patient Access Request to Their Protected Health Information

This form is for patient requests to access (view), receive or send copies of **their own medical information**.

To verify your identity and provide the correct information, please complete the below:

Patient Name _____ Date of Birth _____
Address _____ Phone number _____
City _____ State _____ Zip _____

Facilities or locations from which you are requesting records. Please list or check as appropriate:

CHI St. Joseph’s Health

Dates of Service (please list date or date range for records requested)

From _____ To _____

Parts of the record requested:

(Below are the most frequently requested documents. This does not constitute your entire medical record, which you have the right to request.*)

Check (✓) all that apply:

- Abstract (Includes¹)
- Discharge Summary /Final Diagnosis¹
- History and Physical Records¹
- Consultation Reports¹
- Operations and Procedures¹
- Results of Diagnostic Testing¹
- Emergency Room Records
- Lab Reports
- Radiology (for example: X-Ray) Reports
- Other Diagnostic Reports
- Diagnostic Images (Prepped by Radiology Dept)
- Immunization (shot) Record
- Physical Therapy Notes
- Physician Notes
- Medication List
- Itemized Bill

Other*: _____



I request the form of release of information be ___ Electronic (Portal) ___ Paper (U.S. Mail or pick up) ___ Electronic (Secure Email) (provide email address _____) ___ Other (USB, etc...**) _____

**Device must be provided by the facility

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

I will pick up the records (check here) _____

(or)

Please send the records to the person or party(ies) below at the address provided:

Recipient Name:

Address for receipt of record:

I understand there may be a minimal fee charged for the records.

Signature of Patient or Guardian

_____ Date _____

Print name _____

If you are the Personal Representative of the Patient:

Signature of Personal Representative _____

Authority or relationship to patient _____

(Please include copies of any documents that establish Personal Representation such as Power of Attorney document, Guardianship papers, Executor of Estate or Administrator of will documents.)