

Patient Request for Health Information

Patient Information (Please Print)

Last Name:	First Name:	Middle Initial:	
Name at Time of Treatment (if different from above):			
Date of Birth (MM/DD/YYYY):		Phone:	
Street Address:	City:	State:	Zip:
Requesting Information from (specify Shriners Hospitals for Children Facility): _____			

<input type="checkbox"/> Date(s) of treatment: Specific dates: _____/_____/_____ through _____/_____/_____	
<input type="checkbox"/> Abstract report <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History & Physical <input type="checkbox"/> Operative report <input type="checkbox"/> Radiology reports <input type="checkbox"/> Laboratory reports	<input type="checkbox"/> Progress notes <input type="checkbox"/> Consultation reports <input type="checkbox"/> Radiology images/CD <input type="checkbox"/> Billing Records <input type="checkbox"/> Other: _____
In what format would you like to receive your records? (choose one): <input type="checkbox"/> Paper <input type="checkbox"/> Thumb Drive <input type="checkbox"/> *Email <input type="checkbox"/> Other (specify): _____ <small>**Email is not a secure means of communication. We will encrypt email communications of your records.</small>	
<input type="checkbox"/> Please send copies of my records to: <input type="checkbox"/> Self <input type="checkbox"/> Personal Representative (indicated below): Personal Representative Name: _____ Street Address: _____ City/State/Zip code: _____ Phone number of individual receiving records if not patient: _____ Email address (print clearly): _____	

If I submit this access request form and request to have my information sent to a third party, I understand that information contained in my medical record may contain HIV/AIDS testing, results, and/or treatment records; mental health diagnosis and/or treatment records; alcohol and/or drug abuse diagnosis and/or treatment records.

Processing Your Requested Information:

There may be a fee for copies of requested health information. We will inform you of the fee before providing the requested copies. We will respond to your request within 30 days from the date of receipt. Actual turnaround time is typically shorter. We may require an additional 30 day extension if your health information is not readily accessible or is maintained in an offsite storage facility. We will notify you if we need this extension of time.

***Please include a copy of photo ID with signature for verification purposes.**

 Signature of Patient/Parent Legal Guardian Date/Time _____ AM/PM Relationship to Patient

 Printed Name

Patient Request for Health Information

Shriners Hospitals for Children[®]

Patient Information Label Information

