



Memorial
COMMUNITY HEALTH

REQUEST FOR ACCESS TO OR RELEASE OF PROTECTED HEALTH INFORMATION

INSTRUCTIONS:

PT MRN: _____

Please complete this entire form to request inspection or copies of your personal health information. There are certain circumstances in which your request may be denied. If so, you will be notified of the reasons why. Please allow a minimum of 72 hours after the written requests received for processing and up to 7-10 days for all sent mailed request. Medical record charge includes postage and handling flat fee of no more than \$20.00 (\$0.50pg). §71-8404. Individuals generally have access to their own medical records during and after treatment via Patient Portal. All medical records sent for continuity of care are complimentary.

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

PHONE NUMBER: _____ Email: _____

DATE(S) OF SERVICE REQUESTED _____

PLEASE CHECK BELOW THE INFORMATION, WHICH YOU WOULD LIKE RELEASED:

- Clinic visit notes
- X-ray reports
- Financial record
- Consultation report
- Radiology images
- Other _____
- History & Physical exam
- Lab reports
- Emergency room exam
- Discharge summary

PROHIBITION ON REDISCLOSURE OF DIAGNOSIS, TESTING AND/OR TREATMENT OF: Alcohol use, Drug use, HIV, sexually transmitted disease, Psychiatric disorders and/or mental health information. This information has been disclosed from records protected by federal law. 42CFR Part 2 prohibits any further disclosures of these records without a specific written authorization of the person to whom it pertains, or as otherwise permitted by law.

Purpose of Disclosure: _____ my request _____ Other _____

PLEASE INDICATE THE METHOD OF RELEASE:

Send a copy by U.S. mail to the following address: _____

- Will pick up.
- Electronic: (USB,CD)
- Email: _____

Information will be available at MCHI during normal business hours (8:30 am- 4:00 pm Monday- Friday). Unless other special arrangements are made. All other person designated to pick up the Release requested will need to be submitted in writing with Patient Signature & Date. Please include supporting documentation such as Power of Attorney documents, or other document establishing status as personal representative, when applicable. All medical information disclosed is no longer protected by State or Federal law. Patient may revoke this authorization in writing. This authorization is NOT VALID unless COMPLETED in FULL. I understand that my refusal to sign will not affect my ability to obtain treatment at MCHI. §71-8401-§71-8407

SIGNATURE OF PATIENT OR
PERSONAL REPRESENTATIVE

DATE

RELATION TO PATIENT

WITNESS

DATE

WE WILL NOT PROCESS THIS REQUEST UNLESS IT IS SIGNED BY YOU OR YOUR REPRESENTATIVE.

OFFICE USE ONLY:

Physician Approval: _____

Date sent: _____

Initials: _____