Memorial
COMMUNITY HEALTH

# REQUEST FOR ACCESS TO OR RELEASE OF PROTECTED HEALTH INFORMATION

**INSTRUCTIONS:**
*Please complete this entire form to request inspection or copies of your personal health information maintained by MCHI. There are certain circumstances in which your request may be denied. If so, you will be notified of the reasons why. MCHI cannot process your request if this form is not complete. You will be notified of any fees that may apply.*

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

PHONE NUMBER: _____

**DATES OF SERVICE OR TIME PERIOD OF RECORDS REQUESTED:**_____

**PLEASE CHECK BELOW THE INFORMATION WHICH YOU WOULD LIKE TO REVIEW OR RELEASE:**

| | | |
|---|---|---|
| ____ Clinic visit notes | ____ Consultation report | ____ X-ray reports |
| ____ History and physical exam | ____ Emergency room record | ____ Radiology images |
| ____ Lab reports | ____ Discharge summary | ____ After care plan |
| ____ Financial record | ____ Progress notes | |

Other _____

Purpose of Disclosure: ____ My request ____ Other _____

**PLEASE INDICATE THE METHOD OF RELEASE:**

____ Send a copy by regular mail to the following address

_____

_____

_____

____ Will pick up.

____ Electronic: (by what method) _____ Email Address if needed: _____

____ Inspect the information at MCHI. Information will be available at MCHI during normal business hours (8:30 am to 4:00 pm Monday through Friday) unless other special arrangements are made.

_____ _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____

AUTHORITY OF PERSONAL REPRESENTATIVE

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

---

OFFICE USE ONLY

Date Sent: _____ By (initials): _____