



Patient Label

Patient Request to Access Medical Records Form #CHCR-001 rev. 08/11



AUTHPHI

Patient Request to Access Medical Records Form

Name of Facility/Entity: \_\_\_\_\_

Form with fields: Patient's Full Name, E-mail Address, Street Address, City, State, Zip Code, Phone #, Date of Birth, Last 4 of Social Security #, Driver's License/State-Issued ID #

I'm requesting access to (please check one):

- View Records Only, Obtain Copies of Records

Please complete the following information:

Form with fields: Date(s) of service, Reason for request, Describe the information you are requesting to view or obtain copies of

I certify that this request to access health information is made voluntarily and that the information given above is accurate to the best of my knowledge...

Signature of Patient/Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

If Legal Representative, Print Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Centura Health Use Only: Individual Who Received Request, Date Request Received, Verification of Identity, Medical Record #, Request Approved/Denied, Date Fulfilled, Patient Acknowledgement of Inspection, Reason for Denial

PSYCHIATRIC RECORD PHYSICIAN APPROVAL: I am the attending physician for the above named patient. I have reviewed the medical record(s) to determine if they contain information relative to psychological or psychiatric problems...

These portions of medical record(s): May be released to the patient, May NOT be released to the patient

Signature of Physician or Designee: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Print Name of Physician: \_\_\_\_\_