Centura Health®

Patient Request to Access Medical Records Form
#CHCR-001 rev. 04/18
Epic# 1000 - HIM ROI Authorization

Patient Label

Patient Request to Access Medical Records Form

Name of Facility/Entity: _____

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

☐ Send Records to MyChart Patient Portal
☐ Send Records Via encrypted Email
☐ Personal pick up

☐ Mail Records to address above
☐ Other:_____

Please complete the following information:

Date(s) of service associated with request (e.g. date of treatment, date of office visit):	
If requesting copies, please describe the reason for the request:	☐ Further Medical Care ☐ Worker's Comp ☐ Personal Use ☐ Insurance ☐ Legal ☐ Other: _____
Describe the information you are requesting to view or obtain copies of:	☐ D/C Summary ☐ Labs ☐ Radiology ☐ H&P/Consult ☐ ER Records ☐ Operative Report ☐ Medications ☐ Progress Notes/Phys Orders ☐ Specific Studies ☐ Psych Health ☐ Entire Medical Record ☐ Other: _____

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. I understand that Centura Health may not be able to grant me access to certain types of health information and information belonging to minors between the ages of 13-17 will not be accessible to ensure compliance with legal requirements regarding access to patient records. I understand that if I need to obtain hard copies there may be a charge associated with such copies.

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 (driver's license or other ID): _____

Medical Record #: _____

☐ *Request Approved* ☐ *Request Denied* *Date Approved/Denied:* _____

Date Fulfilled (copies delivered/inspection complete): _____ *Individual Who Fulfilled:* _____

Patient Acknowledgement of Inspection (viewing only). _____ *Date:* _____

Reason for Denial (if applicable): _____

_____

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 which, if revealed to the patient is reasonably likely to endanger the life or physical safety of the individual or another person.

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: _____