CHI Health

CS0020

PATIENT ACCESS REQUEST TO THEIR PROTECTED HEALTH INFORMATION

This form is for patient requests to access (view), receive or send copies of **their own medical information**.

Patient Name		Date of Birth
Previous / Other Name(s)		
Email Address*	Phone	
Street Address		
City	State	Zip Code

Facilities from which you are requesting records. Please check **(✓)** as appropriate.

☐ CUMC-Bergan Mercy	☐ Good Samaritan	☐ Immanuel	☐ Lakeside	☐ Mercy Corning
☐ Mercy Council Bluffs	☐ Midlands	☐ Missouri Valley	☐ Nebraska Heart	☐ Plainview
☐ Schuyler	☐ St. Elizabeth	☐ St. Francis	☐ St. Mary's	
☐ Clinic (Specify) _____		☐ Other (Specify) _____		

Dates of Service: (Please list date or date range of records requested.)	From:	To:

Parts of the record requested:

(Below are the most frequently requested documents. This does not constitute your entire medical record, which you have the right to request.)

☐ Abstract (Includes[1])	☐ Emergency Room Records	☐ Lab Reports
☐ Discharge Summary/Final Diagnosis[1]	☐ Immunization (shot) Record	☐ Physical Therapy Notes
☐ History and Physical Records[1]	☐ Radiology (i.e., X-ray) Reports	☐ Physician Notes
☐ Consultation Reports[1]	☐ Other Diagnostic Reports	☐ Medication List
☐ Operations and Procedures[1]	☐ Diagnostic Images (Prepped by Radiology Department)	☐ Itemized Bill
☐ Results of Diagnostic Testing[1]	☐ Other _____	

I request the form of release of information be:

☐ Electronic (HIM Department Portal) (*Email Address Required) ☐ Paper (U.S. Mail or Pick Up)

☐ Other (USB, etc.**): _____ (**Device must be provided by the facility.)

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

☐ I will pick up the records (or)

☐ Please send the records to the person or party(ies) below at the address provided:

Recipient Name	Email Address for Receipt of Records*	
Street Address		
City	State	Zip Code

I understand there may be a minimal fee charged for the records.

Signature of Patient or Personal Representative	Date (Required)
Print Name	
If Personal Representative of the Patient, Authority or Relationship to Patient (e.g., parent, legal guardian)	

(Please include copies of any documents that establish Personal Representative such as power of attorney document, guardianship papers, executor of estate or administrator of will documents.)