



C S 0 0 2 0

PATIENT ACCESS REQUEST TO THEIR PROTECTED HEALTH INFORMATION

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

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

<input type="checkbox"/> CUMC-Bergan Mercy	<input type="checkbox"/> Good Samaritan	<input type="checkbox"/> Immanuel	<input type="checkbox"/> Lakeside	<input type="checkbox"/> Mercy Corning
<input type="checkbox"/> Mercy Council Bluffs	<input type="checkbox"/> Midlands	<input type="checkbox"/> Missouri Valley	<input type="checkbox"/> Nebraska Heart	<input type="checkbox"/> Plainview
<input type="checkbox"/> Schuyler	<input type="checkbox"/> St. Elizabeth	<input type="checkbox"/> St. Francis	<input type="checkbox"/> St. Mary's	
<input type="checkbox"/> Clinic (Specify) _____		<input type="checkbox"/> 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.)

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

I request the form of release of information be:

<input type="checkbox"/> Electronic (Portal)	<input type="checkbox"/> Electronic (Secure Email) – Email Address: _____
<input type="checkbox"/> Paper (U.S. Mail or Pick Up)	<input type="checkbox"/> 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		
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.)