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) ☐ Other: _____

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.)***