

## Request to Inspect or Copy Health Information

Please submit this request to our Privacy Officer/Contact Person. If you have any questions, comments or complaints, or would like to review or obtain a copy of our Notice of Privacy Practices, please contact the Privacy Officer at the above number.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ MRN: \_\_\_\_\_

Date of Treatment: \_\_\_\_\_

### RECORDS REQUESTED:

- Billing information
- Diagnostic study results (laboratory, radiology, pathology) \_\_\_\_\_
- Discharge instructions
- Emergency Department record
- Immunization records
- Medication records
- Multi-disciplinary notes
- Procedure reports
- History and Physical Examination
- Therapy/rehabilitation records

Please specify the type of access you request (copying or inspection): \_\_\_\_\_

Where may we contact you with questions about this request or to set up a time to inspect the records if requested:  
\_\_\_\_\_

Please indicate method of delivery if copies are requested:

- I will pick up the records from the Hospital
- Please fax. My fax number is \_\_\_\_\_
- Please mail the records to the following address

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I request access to the health information and records indicated on this form as set forth above. I certify that the records sought are my own or that I am the personal representative of the patient whose records are sought and am authorized to make this request.

\_\_\_\_\_  
Signature of Patient or Patient's Personal Representative

\_\_\_\_\_  
Date

Personal Representative's Relationship to Patient: \_\_\_\_\_