

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**.

To verify your identity and provide the correct information, please complete the below:

Patient Name _____ Date of Birth _____
 Address _____ Phone number _____
 City _____ State _____ Zip _____

Facilities or locations from which you are requesting records. Please check as appropriate:

- CHI St. Gabriel's Hospital
- Family Medical Center Little Falls
- Family Medical Center Pierz
- Family Medical Center Randall
- Little Falls Ortho

Dates of Service (please list date or date range for 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.*)

Check (✓) all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Abstract (Includes ¹) | <input type="checkbox"/> Emergency Room Records |
| <input type="checkbox"/> Discharge Summary /Final Diagnosis ¹ | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> History and Physical Records ¹ | <input type="checkbox"/> Radiology (for example: X-Ray) Reports |
| <input type="checkbox"/> Consultation Reports ¹ | <input type="checkbox"/> Other Diagnostic Reports |
| <input type="checkbox"/> Operations and Procedures ¹ | <input type="checkbox"/> Diagnostic Images (Prepped by Radiology Dept) |
| <input type="checkbox"/> Results of Diagnostic Testing ¹ | <input type="checkbox"/> Immunization (shot) Record |
| | <input type="checkbox"/> Physical Therapy Notes |
| | <input type="checkbox"/> Physician Notes |
| | <input type="checkbox"/> Medication List |
| | <input type="checkbox"/> Itemized Bill |

Other*: _____

I request the form of release of information be Electronic (Portal) Paper (U.S. Mail or pick up)
 Electronic (Secure Email) (provide email address _____)
 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 (check here) _____
(or)

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

Recipient Name:

Address for receipt of record:

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

Signature of Patient or Guardian

_____ Date _____

Print name _____

If you are the Personal Representative of the Patient:

Signature of Personal Representative _____

Authority or relationship to patient _____

(Please include copies of any documents that establish Personal Representation such as Power of Attorney document, Guardianship papers, Executor of Estate or Administrator of will documents.)