

## PATIENT ACCESS FORM

<b>Section A: This section must be completed for all requests for access</b>					
<b>Patient Last Name</b>		<b>First Name</b>		<b>MI</b>	
<b>Date of Birth</b>		<b>Social Security Number (optional):</b>			
<b>Address:</b>					
<b>City:</b>		<b>State:</b>		<b>Zip:</b>	
<b>Phone Number:</b>			<b>Email Address:</b>		
<b>Name at time of treatment, if different than above:</b>					
<b>Name and address of health provider or entity who will provide you with access to this information:</b>					
<b>Where do you want the information sent? Self or Personal Representative (indicated below)</b>					
<b>Personal Representative Name:</b>					
<b>Address:</b>					
<b>City:</b>		<b>State:</b>		<b>Zip:</b>	
<b>Phone Number:</b>			<b>Email Address:</b>		
<b>Fax Number:</b>					
<b>What records are you requesting?</b>					
<i>Description:</i>	<i>Date(s):</i>	<i>Description:</i>	<i>Date(s):</i>	<i>Description:</i>	<i>Date(s):</i>
<input type="checkbox"/> All Protected Health Information in medical record <input type="checkbox"/> Admission form  <input type="checkbox"/> Physician orders <input type="checkbox"/> Medication Sheets <input type="checkbox"/> Lab Tests		<input type="checkbox"/> Discharge Summary <input type="checkbox"/> Progress Notes <input type="checkbox"/> Initial Evaluation <input type="checkbox"/> Itemized bill <input type="checkbox"/> History and Physical exam <input type="checkbox"/> Radiology Reports		<input type="checkbox"/> Other: <input type="checkbox"/> Other: <input type="checkbox"/> Other:	
Please describe the exact nature and dates of medical records that you would like. _____					
Preferred method of delivery: <input type="checkbox"/> secure email <input type="checkbox"/> mail <input type="checkbox"/> pick up of paper copies <input type="checkbox"/> fax <input type="checkbox"/> patient portal (where available) <input type="checkbox"/> Other electronic method (USB, CD, other). Please specify: _____					

Please print your name and sign below:

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Relationship

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

\_\_\_\_\_  
Date

Select Medical recognizes a patient's rights under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.