ROI

Patient Information (Please Print)

First Name: Middle Initial: Last Name:

Name at Time of Treatment (if different than above):

Date of Birth (MM/DD/YYYY): Phone: E-mail (optional):

Street Address: City: State: Zip:

I am requesting my records from:

Facility Name: **Facility E-mail:**

Address: **Facility Fax:**

City/State Zip:

What records do you want to receive or have disclosed to the recipient noted? (Check appropriate boxes below):

Date(s) of Service: ____/____/_____ through ____/____/_____

Progress Notes Emergency Room Record Discharge Summary History and Physical
Consultation(s) Lab Reports Pathology Report Operative Note(s) Imaging/X-Ray Films
Imaging/X-Ray Reports Entire Record Fetal Heart Monitor Strips
Other (specify)_____

_____

If it exists, the following Sensitive Information can be disclosed:

Alcohol Abuse Drug Abuse Communicable diseases, including HIV status
Genetic Testing Psychiatric/Behavioral Diagnoses

How would you like your records delivered?

Paper
Electronic: Email (I understand that there is a risk to me when my information is transmitted via an unsecured e-mail system, and the information could be accessed by a third party during the transmission process. By checking the box to request Email delivery I accept this risk.)
USB or CD
Password Protected Not Password Protected
Mail to address below I will pick up in person

If mailing, where do you want the information sent? (Fill in boxes below):

Please provide my records to: Myself Personal Representative (indicated below) Other Third Party (indicated below)

Recipient Name: Recipient Phone:
Recipient Fax:

Recipient Mailing Address: Recipient E-mail (if applicable):

Please print your name and sign below:

Name of Patient or Personal Representative (please print) **Relationship (please print)**

Patient's Signature or Legal Representative — Date/Time

Relationship to Patient / Authority to Act on Patient's Behalf — Interpreter, if Utilized — Date/Time

Witness Signature — Date/Time

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

Patient Request for Health Information
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04/18 (Rev. 08/18, 01/20, 02/20, 06/21)

Patient Label

Crestwood Medical Center