

PATIENT REQUEST FOR HEALTH INFORMATION

PATIENT INFORMATION (PLEASE PRINT)

Patient Name			
Address			
City/State/Zip			
Date of Birth	/ /	Phone #	

WHAT RECORDS DO YOU WANT?

I understand that this information may include information relating to: AIDS, HIV, diagnosis/treatment of drug or alcohol abuse; mental, behavioral health, or psychiatric care.

<input type="checkbox"/> Summary (doctor notes, emergency room record, test results, operations)	<input type="checkbox"/> Laboratory Reports
<input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Room Record <input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Other
<input type="checkbox"/> History/Physical <input type="checkbox"/> Operative Report(s) <input type="checkbox"/> Radiology Images	
Date(s) of Service:	

HOW WOULD YOU LIKE YOUR RECORDS DELIVERED?

<input type="checkbox"/> Paper:	<input type="checkbox"/> I will pick up in-person	<input type="checkbox"/> Mail To Home (address below)
<input type="checkbox"/> CD:	<input type="checkbox"/> I will pick up in-person	<input type="checkbox"/> Mail To Home (address below)
<input type="checkbox"/> Email:	I would like my copy sent to me electronically via e-mail using the following e-mail address: <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> WARNING: I understand there is a level of risk that my PHI could be read or otherwise accessed by a third party while in transit and agree to receiving my PHI by unencrypted e-mail using the e-mail address above. My signature indicates I understand and accept the risk. </div> <div style="text-align: right;">(Signature of patient)</div>	
<input type="checkbox"/> Other		

WHERE DO YOU WANT YOUR RECORDS SENT?

Please provide my records to: <input type="checkbox"/> Myself <input type="checkbox"/> My Personal Representative (indicated below):		
Recipient Name	Recipient Telephone #	
Recipient Street Address	Recipient City, State Zip	Recipient Fax or Email (if applicable)

Facility checked above 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.

Signature of Patient/Authorized Representative

Date

Printed Name of Patient or Legal Guardian

Relationship to patient, if other than self
(attach appropriate legal documents)

Please Return Completed Form to: HIM Department
1 Bay Avenue Montclair, NJ 07042

For questions about completing this form
please call 973-429-6042

For Hospital Staff use:

MR/Acct #: _____ ID Verified: _____

Processed by: _____ on _____ via _____

Notes: _____