MERCYHEALTH

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Initials
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Date

PATIENT REQUEST TO ACCESS OR COPY HEALTH INFORMATION

Complete all sections entirely. If this request is not complete, it may be returned and result in delay in processing. Photo ID required at the time of request and pick up.

Patient name:	**Date of Birth:**	**Last 4 digits of SS#:**	**Telephone #:**

Address: _____
Street City State Zip Code

Mercy Health Hospital or Physician office health information requested from: (Check all that apply)

☐ Mercy Regional Medical Center ☐ Mercy Allen Hospital ☐ Cancer Center ☐ HealthSpan

☐ Physician/Practice Name:_____ ☐ Other Healthcare Provider:_____

Dates of service to release: (from): _____ (to):_____

Specific reports to be disclosed: (Check all that apply)

☐ Abstract of record (Discharge Summary, H&P, Operative Report, Consults, Test results….) ☐ Office Visit

☐ Emergency Department record ☐ History & Physical ☐ Operative report ☐ Discharge Summary

☐ Immunization record ☐ Test results (Lab, Pathology, Radiology, and Cardiac)

☐ Other (Images, Photos): _____

☐ Entire record (standard two years of information, unless otherwise specified): _____

If pick up or mailing records, format selected: ☐ Paper ☐ Electronic (CD)

Information to be disclosed via: (Check one)

Name of requestor (if different): _____

☐ Mail to address above

☐ Fax to number: _____ (page limitation may apply)

☐ Email to: _____ (I acknowledge and accept the risks associated with unsecure transmission and Mercy Health is not liable for disclosures that occur in transit. I acknowledge file size limitations. If file cannot be sent by email due to file size, I will provide mailing address or will pick information up)

☐ Pick up location/site: _____

- I understand and acknowledge there is no charge to access (read/review) my health information or to provide me with a copy of specific reports/tests/abstract. (by appointment 24/48 hour notice required) If I request my entire record of health information, there will be a fee. Health information maintained in electronic format and provided in electronic or paper media will be $6.50 flat fee. Health information maintained in paper format will $0.10 per page.
- I understand and acknowledge if I am requesting my health information while I am In House/Admitted or receiving on-going services, my record may not be complete and I will need to request after services are completed and finalized

_____ _____
Signature of Patient/Patient's Legal Representative Date

Relationship to patient: _____ *(Supporting documentation of authority must be provided)*

Witness (optional):_____