Mercy | Occupational Medicine

REQUEST TO RELEASE PROTECTED HEALTH INFORMATION

INFORMATION TO BE RELEASED TO:	INFORMATION TO BE RELEASED TO:

Patient's Name: _____ **Patient's Date of Birth:** _____
Patient's Address: _____
Patient's Phone Number: _____
I request a copy of the following PHI (please check the boxes below):

☐ **All Medical Records**	☐ **X-ray Images**	☐ **Radiology Reports**	☐ **Other (*specify*):** _____
☐ **Physician Office Notes**	☐ **X-ray Reports**	☐ **Mammogram Reports**	_____
☐ **Discharge Summary**	☐ **Laboratory Reports**	☐ **Physician Orders**	_____
☐ **History/Physical**	☐ **EKG**	☐ **Emergency Dept. Records**	_____
☐ **Consultation Reports**	☐ **Pathology Reports**	☐ **Billing Statements**	_____
☐ **Operative Reports**	☐ **Progress Notes**	☐ **Abstract of Health Information**	

Date(s) of Service of PHI Requested *(If no specified dates, records will be provided for all dates of service)*:

From Date: _____ To Date: _____

***IMPORTANT:* *If my record contains information regarding drug/alcohol abuse, mental health treatment, HIV/AIDS testing or treatment, genetic information, communicable diseases or other sensitive information I request that such information be included with my records*:**
☐ **Yes (include with my records)** ☐ **No (do not include with my records)**

I request that PHI specified above be provided:

- ☐ To me
- ☐ To following person/entity: _____
  (Specify name and address of person/entity to whom you would like your PHI to be sent)

I request that PHI be provided in the following format (if readily reproducible in this format):

- ☐ Mailed Paper Copy – Address: _____
- ☐ PDF Attachment via Secure Email: _____
- ☐ Fax: _____
- ☐ Other: _____

I understand that I may be charged a reasonable fee for the costs of labor for copying, postage, supplies as permitted by HIPAA Privacy Rule and state law.

Printed Name:
Signature:
Date:
Access Requested By: (Check One)
☐ **Patient** ☐ **Parent (Minor)** ☐ **Personal Representative**
If this request is signed by the patient's personal representative, please specify your authority to act on behalf of the patient and attach supporting documentation:

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