Patient Request for Health Information

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Address:	City:	State:	Zip:

What records do you want? (Check appropriate boxes below):

Date(s) of service: ____ / ____ / ____ through ____ / ____ / ____ **OR** □ Health care at any time

□ History and Physical	□ Last PO Intake	□ Radiology Report
□ Nurses Notes	□ Operative Report	□ Radiology Images
□ Pathology Report	□ Discharge Summary	□ EKG
□ Physician Progress Notes	□ Physician's Orders	□ Lab Reports
□ Emergency Room Record	□ Consultation Report	□ ALL

□ Billing and payment records for care rendered during the relevant time period.
□ Other (Immunization Records, Medications) Specify: _____

How would you like your records/information delivered?

Paper: □ Mail delivery □ In-Person Pickup

Electronic: □ Secure email □ Unsecure Email □ CD

Other: □ Verbal □ ALL

UNSECURE EMAIL: *I consent and accept the risk of transmitting PHI via unencrypted e-mail.* _____ (initials)

I want □ Madison Memorial Hospital □ Madison Surgery Center □ Rexburg Medical Clinic □ Madison Orthopedics □ Seasons Medical □ Madison Foot and Ankle □ Rigby Medical Center □ Upper Valley Orthopedics □ ALL

to provide my records to: □ Self □ Personal Representative (indicated below) □ Third-Party (indicated below)

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (if applicable):

Expiration: Unless otherwise revoked, this request will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this request will expire one year from the date this request is dated.

Signature of Patient or Personal Representative _____ Date _____

OFFICE USE ONLY **Identity Verification** *(Employee processing this request must complete the following):*

In-Person/Mail (Patient):	□ Driver's lic.	□ Sig. in chart	□ Other:	
In-Person/Mail (3rd party):	□ Driver's lic.	□ Sig. in chart	□ Other:	
Telephone (Patient):	□ SSN or DL#	□ DOB	□ Presenting illness	□ Address (3 of 4 required)

Employee's initials: _____

Date disclosed ____ / ____ / ____ □ Info already disclosed □ HIM needs to disclose