Patient Request for Access to Health Information

Patient Name: _____ Date of Birth: _____

Street Address: _____ Last 4 numbers of SSN: _____

City, State, Zip: _____ Telephone: _____

Email address: _____

By providing your email address, you acknowledge and accept the risks outlined in Guidelines for E-mail, posted on murphymedical.org.

I would like for _____ **to (choose one):**

(list facility or practice)

- ☐ **give me a copy of my health information**
- ☐ **send my records to:**

_____

(Name of Facility, Person, Company) (Street Address or PO Box, City, State, Zip Code)

_____

(Phone Number) (Fax Number)

_____

(E-mail Address)

I would like these dates of service to be released: _____

I want these parts of my record:

Hospital (check all that may apply):	**Office/Clinic (check all that may apply):**	
☐ Hospital Summary ☐ Discharge Summary ☐ Emergency Record ☐ History and Physical ☐ Operative Reports ☐ Laboratory reports ☐ Radiology/X-Ray Reports ☐ Other_____ ☐ Entire record ☐ Itemized Bill	☐ Office/Clinic Summary ☐ Office Visits ☐ Physical Exam ☐ Laboratory Reports ☐ Radiology Reports ☐ Other_____ ☐ Entire Record ☐ Itemized Bill	

I want these records as a (choose one):

- ☐ **CD**
- ☐ **E-mail**
- ☐ **Paper copy**
- ☐ **Other:** _____

I want you to (choose one):

- ☐ **Mail them**
- ☐ **Send them secure e-mail**
- ☐ **Fax them to:** _____
- ☐ **Prepare them to be picked up by:** _____

As an alternative, you may schedule an appointment with your healthcare provider's office to see your record in person. Please note it may take up to 30 days to schedule the appointment or provide copies.

Signature: _____ **Print Name:** _____

Relationship to Patient: _____ **Date:** _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this for the patient. (Written Proof May be Requested)

MMC Use Only

Date of release: _____ ☐ ID Verified ☐ DL/Other ID _____ MMC Employee _____

Murphy Medical Center

Murphy Medical Center, Inc.
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