



**PATIENT REQUEST FOR ACCESS
TO HEALTH INFORMATION**

GLHS recognizes a patient's right of access under HIPAA.

Patient Name: _____ Patient Date of Birth: _____

1. Request access for Dates of Service: _____

OR Any and All Past, Present and Future information (until revoked in writing)

2. Information to be accessed or released: (check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> ER Chart | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Urgent Care Chart | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> All Dictated Reports |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Medical Imaging Reports | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Discharge Instruction Sheet | <input type="checkbox"/> EKG | _____ |

3. Requestor: Self (Patient)

Patient Representative; Name _____

Parent/Guardian HPOA Executor of Estate Other: _____

4. How would you like your records delivered?

Paper

In-Person Pickup (self)

Allow someone else to pick up my records; Name: _____

Mail Delivery; Street Address: _____

City/State/Zip: _____

Inspect Originals

Electronic Copy (USB, email, CD-images); Please Specify: _____
_____ (patient initials)* NOTE: EMAIL is NOT a secure method of sending medical information. I understand I am requesting my information to be sent in a non-secure method.

Fax copies of Lab Results to Patient (Note: Confirm with patient that their fax machine is in a secure location) (GLHS is not responsible for unauthorized disclosure as a result of an unsecured patient fax machine). Patient Initials _____

Release Lab Results over the phone. Please provide a password _____ (GLHS is not responsible for unauthorized disclosure as a result of someone other than the patient calling to receive Lab Results over the phone with above identified password). Patient Initials _____

Signature of Patient or Representative

Date

For Internal use only:

Patient MRN #:	Patient Visit #:	
Date Requested:	Date Completed:	Completed By: