



**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 ONLY ONE box below)
 - ALL Grand Lake Health System Records: Joint Township District Memorial Hospital (JTDMH) and all Physician Practice records
 - Joint Township District Memorial Hospital records ONLY (this includes ER, Inpatient, Urgent Care, Outpatient testing, Outpatient Services, Rehab/Therapy, Outpatient Clinics (Pain/Sleep/IV, etc)
 - ONLY specific portions of the JTMDH record:

<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/CD	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Discharge Instruction Sheet	Images	
	<input type="checkbox"/> EKG	
 - ALL Grand Lake Physician Practice Records (ALL Offices, including family practice and specialty)
 - ONLY records from specific Physician Practice Office; Office Name: _____

3. Requestor: (check one) Self (Patient) Patient Representative; Name _____
 IF Patient Representative, check one below AND validate parent OR documents
 Parent/Guardian HPOA Executor of Estate Other: _____

4. How would you like record copies delivered? (check all that apply)
 - Paper Copy Electronic Copy via USB/Flash Drive (ONLY on device supplied by GLHS)
 - In-Person Pickup (self)
 - Allow someone else to pick up my records; Name: _____
 - Mail Delivery; Street Address: _____
 City/State/Zip: _____
 - Email Copy; email address: _____ * 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. _____ (patient initials)
 - Fax copies 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: