SIH MEDICAL GROUP

PATIENT | PERSONAL REPRESENTATIVE REQUEST FOR ACCESS TO HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
Last First MI

Name of Provider/Practice: _____

Specific Health Information Requested: Date of Treatment: _____

- ❒ Lab Report
- ❒ Pathology Report
- ❒ Imaging Report
- ❒ EKG
- ❒ Immunization Record
- ❒ Physical
- ❒ Office Visit Note
- ❒ Other_____

Please circle the type of access requested: (1, 2 or 3) :

1 **Obtain a copy**

Request Format:

❒ Paper copy ❒ Download to DVD ❒ Download to SIH provided Flash Drive

Delivery Method:

❒ I will pick up ❒ Mail to me at address below ❒ Fax* #_____

❒ Send to another individual/organization at address below

_____

_____

(Name and Address)

2 **Transmit a copy via PDF to my email***

My email address is: _____

3 **Inspect health information contained in the medical record and billing system.** (Please contact the Health Information Department to arrange.)

Signed: _____ Date: _____
(Patient / Legal Representative)

If signed by other than the patient, please indicate legal relationship :_____

_____

We ask for your signature as a method to further verify your identity and protect your health information from wrongful access by others.

❒ Records Released at Provider Office _____ Date: _____
(Employee Name/Department)

❒ Records to be Released by Health Information _____ Date: _____
(Employee Name/Department)

*Sending your personal health information to an email address or by fax is not a secure delivery method and may expose your health information to others. By choosing this delivery method, you release Southern Illinois Healthcare/Southern Illinois Healthcare Medical Group from any liability involving a potential or actual breach of your health information that has been delivered upon your request to an email address or by fax.

If you have any questions regarding completing this form, please contact the Health Information Department.

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