Howard Memorial hospital

REQUEST FOR MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Phone Number: _____

Last Four Digits of SSN#: _____

Address: _____

_____

Email Address: _____

As the patient, or the patient's personal representative, I am requesting a copy of the medical record held by Howard Memorial Hospital

Date(s) of Service Requested: _____

☐ Summary of Record
☐ Entire Medical Record
☐ Emergency Room Record
☐ Radiology
☐ Laboratory
☐ Operative/Pathology Report
☐ Immunization Records
☐ Other Information

Does request include a virtual visit?

Yes ☐ No ☐

Please deliver to:

Patient: ☐

Other ☐ (Provide name and address)

_____
_____
_____

I understand the record may include information relating to mental healthcare, communicable diseases, and treatment of alcohol or drug abuse. NOTICE: Once your PHI has been disclosed in accordance with this request, it may be re-disclosed to individuals or organizations that are not subject to the HIPAA regulations.

I request the record to be provided in the following format:

☐ **paper** ☐ **USB** ☐ **secure portal** ☐ **unsecure email** _____

☐ **fax** _____

I understand if I request the record to be provided by email that I undertake the following potential risks - ***the information may be obtained by someone else, the information can be opened and read by someone else, unencrypted information does not provide any assurance of privacy or security.***

_____ _____
Patient Signature Date

_____ _____
Legal Representative, if not patient Date