Access Request Form by Patient/Personal Representative

MRN: _____

_____ _____

Please Print Name of Individual/Maiden/AKA if applicable (Last, First, MI) DOB (MM/DD/YYYY)

_____ (_____)_____

Address City State/Zip Phone Number

Dates of Service (if known): From _____To _____

Location the service took place:

☐ Aultman Hospital ☐ Aultman Orrville Hospital ☐ Aultman Alliance Hospital ☐ Aultman NOW

☐ Aultman Medical Group: _____ ☐ Other: _____

Practice Name

I request only the following information to be disclosed:

Please check all that apply

☐ All Records	☐ History & Physical	☐ Nuclear Med. Reports	☐ Progress Notes
☐ Abstract of record **(Office notes, Procedures & Test Results Only, etc.)**	☐ Itemized Billing Statements	☐ Nurses Notes	☐ Radiology Reports
	☐ Laboratory Reports	☐ Operative Reports	☐ Other (Specify in detail):
☐ Diagnostic Images	☐ Medication Records	☐ Other Procedure Report	_____
☐ Discharge Summary	☐ Monitoring Strips	☐ Pathology Reports	_____

Please indicate the type of access requested by checking the appropriate box and complete the section:

☐ Request copy for **myself: (Confirm patient ID)**

Requested format: ☐ Paper Copy ☐ CD ☐ Other: _____ ☐ Email

Requested delivery method: ☐ I will pick up ☐ Mail to me at the address below ☐ Email to address below*

_____

(Mailing/Email Address)

☐ Request copy for a **3rd Party:**

Requested format: ☐ Paper Copy ☐ CD ☐ Other: _____ ☐ Email

Requested delivery method: ☐ I will pick up ☐ Mail to me at the address below ☐ Email to address below*

_____

(Mailing/Email Address)

☐ **Inspect** health information contained in the medical record or billing system. Please contact the Aultman location where your received your service(s) to arrange.

*Email is not a secure means of communication. Aultman will encrypt email communications of your records unless you tell us to use unencrypted email. If you prefer we **NOT ENCRYPT** our communications to you, **please initial here: _____.** By choosing unencrypted email, you release Aultman from any liability involving a potential or actual breach of your health information that has been delivered upon your request to an email address.

Aultman may charge a fee for copying requested health information plus postage for mailing copies to you. If you request a copy of your record to be provided on a portable media such as CD or USB drive, we may charge you the cost of the portable media. Aultman will respond to your request for health information within 30 days of receipt of your request. If additional response time is required, we will notify you of the extension.

Signature:_____ Date:_____

Patient/ Personal Representative (required if recipient is a 3rd Party)

Description of legal authority (if applicable):_____

Office Use Only: Verbal Request; Yes____ No ____ If Yes, Form Completed by: _____ Date: _____ Time: _____

Records Released by: _____ Date: _____ Pages Released: _____