Patient Request for Access to Protected Health Information

Patient Information: I request the release of health information related to: (One patient per form)

Patient name: ____________________ Date of birth: ____________________

Street address: ____________________ Last 4 numbers of SSN: ____________________

City, state, zip: ____________________ Telephone: ( ) ____________________

Email address: ____________________

Although Novant Health will use reasonable means to protect the security and confidentiality of emails sent and received, we cannot guarantee the security and confidentiality of all email communications.

Release information from:

____

(list applicable facility(s) and/or practice(s))

____

____

Release information to:

____

(name of facility, person, company) (relationship)

____

(street address or PO box, city, state, zip code)

____

(phone number) (fax number)

Please fill in dates of treatment for records to be released: Treatment dates FROM: ____________________ **TO:** ____________________

Hospital (check all that apply):

- ☐ **Hospital abstract**
  - ☐ History and physical
  - ☐ Discharge summary
  - ☐ Operative reports
  - ☐ Consultation reports
  - ☐ Diagnostic test results
  - ☐ Medications
  - ☐ Allergies
  - ☐ Physician orders
  - ☐ Progress notes
  - ☐ Emergency record
  - ☐ Cardiac reports/EKG
  - ☐ Laboratory reports
  - ☐ Radiology/X-Ray reports
  - ☐ Pathology reports
  - ☐ Billing Information
  - ☐ Other: ____________________
- ☐ Entire record (not including psychotherapy notes)

Office/Clinic (check all that may apply):

- ☐ **Office/clinic abstract**
  - ☐ Office visits
  - ☐ Physical exam
  - ☐ Consultation reports
  - ☐ Diagnostic test reports
- ☐ Laboratory reports
- ☐ Radiology reports
- ☐ Medications
- ☐ Billing information
- ☐ Other: ____________________
- ☐ Entire record (not including psychotherapy notes)

Format – charges may apply (only select one):

☐ Paper copy ☐ Electronic copy

☐ CD ☐ Other: ____________________

Delivery Method:

☐ Regular US mail ☐ Pick-up ☐ Email ☐ Fax

☐ Other: ____________________

I understand that this is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.

Signature: ____________________ Print name: ____________________ Date/Time: ____________________

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.

Identify the relationship/authority if signature is not that of the patient (written proof may be requested):

☐ Healthcare agent/POA ☐ Guardian ☐ Executor/administrator/attorney in fact ☐ Parent ☐ Next of kin

☐ Other: ____________________

Signature of minor: ____________________ Print name: ____________________ Date/Time: ____________________

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted ____________________ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

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803680 R 07/20/2016

Patient Name:____________________

DOB:____________________

(or use patient label)

Name / MR # / Label