Patient Request for Access to Protected Health Information

Did you know you can view most of your medical record online via MyChart? Go to www.novanthealth.org and click on the *Patients & visitors* tab to visit our MyChart page to learn more. If you would like a copy of your medical record please complete the form below.

I am a patient of Novant Health and my information is listed below:

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 e-mails sent and received, we cannot guarantee the security and confidentiality of all e-mail communications.

I would like for _____ to (choose one):

(List facility or practice)

☐**give me a copy of my health information**

☐**send my records to:**

_____

(Name of Facility, Person, Company) (Street Address or PO Box, City, State, Zip Code)

_____

(Phone Number) (Fax Number)

_____

(E-mail Address)

I would like these dates of service to be released: From: _____To: _____

I want these parts of my record released:

Hospital (check all that may apply):

☐ **Hospital Abstract**

- ☐ History & 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 Results

☐ Laboratory Reports

☐ Radiology Reports

☐ Medications

☐ Billing Information

☐ Other:_____

☐ Entire Record (not including psychotherapy notes)

I want these records as a (choose one):

☐**CD**

☐**E-mail**

☐**Paper copy**

☐**Other:** _____

I want you to (choose one):

☐**Mail them**

☐**Send them secure e-mail**

☐**Fax them to:** _____

☐**Provide them in-person** *(only available for limited amount of information)*

I understand that this is a full release which may include information related to mental health, substance abuse, genetic information, HIV/AIDS, and other sexually transmitted diseases. Please note it may take up to 30 days to process your request.

Signature: _____ **Print Name:** _____ **Date/Time:** _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this for the patient. Identify the relationship/authority if signature is not that of the patient *(Supporting documentation is required)*:

☐**Healthcare Agent/POA** ☐**Legal Guardian** ☐**Executor/Administrator/Attorney in fact** ☐**Parent** ☐**Next of Kin** ☐**Other:**_____

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

☐ Interpreter accepted _____ ☐ Interpreter refused

(Name/number of person/services chosen/used)

NOVANT HEALTH

Patient Request for Access to Protected Health Information

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Patient Name: _____

DOB: _____

Or label

Name / MR # / Label