MOUNT CARMEL
Medical Group

REQUEST FOR PATIENT ACCESS TO PROTECTED HEALTH INFORMATION (PHI)

Printed Patient's Name:_____ Phone: _____

Patient's Address:_____ City, State & Zip Code: _____

Patient's Date of Birth:_____ Patient's Social Security Number (last 4 digits): XXX – XX –_____

DESCRIPTION OF MEDICAL RECORDS REQUESTED

My request for access includes information concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, AIDS/HIV, psychiatric/psychological/mental health conditions or treatment which are contained in the records I indicate below.

Physician/Site from which you are requesting records:

Name:_____

List Date(s) of Treatment _____

Please select records:

☐ Physician Progress Note ☐ Lab/Test Results ☐Radiology Reports
☐ Immunization Record ☐2-year Record Summary ☐Complete Medical Record
☐ Other (list) _____

RECIPIENT OF THE MEDICAL RECORDS: I direct the medical records described above be provided to:(**check all that apply)**

☐ Patient/self (on-site inspection and/or via the format indicated below)

☐ Third party: _____ [insert name of third party]

Address: _____ [insert mailing address]

FORMAT REQUESTED:(check only one option)

☐ Paper ☐ CD ☐ Email _____

ELECTRONIC MAIL (complete this section only if records are being sent via electronic mail to the email address above)

☐ secured/encrypted email ☐* unsecured/unencrypted email (check one option)

**If you checked "unsecure email" please be aware there is some level of risk that your medical information could be read or otherwise accessed by a third party while in transit. By signing below you have accepted this risk and still want your medical information sent by unencrypted email.*

**If records are unable to be emailed due to size limitations, please select an alternative format: ☐ Paper or ☐CD

SIGN HERE_____

Signature of Patient or Personal Representative Date

Printed name of patient's Personal Representative, if applicable_____

Describe Relationship to patient (e.g. minor's parent, guardian) _____

Completed form can be submitted in person or mailed to your Mount Carmel Medical Group Physician Office or emailed to HimMCMG@mchs.com.