**PATIENT INFORMATION**

Printed Patient's Name _____ Phone (_____)_____-_____

Address _____

Patient's Birthdate _____ Social Security Number (last 4 digits) _____

**DESCRIPTION OF MEDICAL RECORDS REQUESTED**

My request for access may include 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 indicated below.

**Please select the Mount Carmel facility from which you are requesting records:** ☐ Mount Carmel East
☐ Mount Carmel St. Ann's ☐ Mount Carmel Grove City ☐ Mount Carmel New Albany ☐ Mount Carmel Dublin
☐ Hillard ☐ Lewis Center ☐ Diley Ridge Medical Center ☐ Reynoldsburg ☐ Franklinton ☐ Other _____

List Date(s) of Treatment _____

**Please select records:**

| | | |
|---|---|---|
| ☐ Emergency Department Records | ☐ Discharge Summary | ☐ History and Physical |
| ☐ Consultations | ☐ Operative Report | ☐ Pathology |
| ☐ Progress Notes | ☐ Test Results | ☐ Complete Medical Record (Fee applied) |
| ☐ Radiology Imaging | ☐ 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: _____ (name of third party)

Address _____ (mailing address of third party)

**FORMAT REQUESTED:** (check only one option)

☐ MyChart (must have an active MyChart account) for dates of service October 9, 2021 to present.
☐ Paper ☐ CD ☐ Email address _____

**If you choose email, insert email address and choose secured or unsecured below**

☐ secured/encrypted email ☐ unsecured/unencrypted email *

**If you checked "unsecured 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) _____

**DELIVER THE COMPLETED SIGNED AND DATED FORM VIA:**

**Fax:** 614-234-9670 **Email:** ROI@mchs.com
**Mailed:** 500 South Cleveland Avenue, Suite 208, Westerville, Ohio 43081
**In person:** To the HIM Department at Mount Carmel East, or Mount Carmel St. Ann's.


Mount Carmel, Columbus, Ohio

**Request for Patient Directed Access to PHI**

HIM 114-1-25

NAME

DOB

MR #

CSN #