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 ☐ 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.

DT0195

Mount Carmel, Columbus, Ohio

Request for Patient Directed Access to PHI

HIM 114-4-23

NAME

DOB

MR #

CSN #