



Patient Label

Patient Request to Access Medical Records Form #CHCR-001 rev. 08/11



AUTHPHI

Patient Request to Access Medical Records Form

Name of Facility/Entity: _____

Form with fields: Patient's Full Name, E-mail Address, Street Address, City, State, Zip Code, Phone #, Date of Birth, Last 4 of Social Security #, Driver's License/State-Issued ID #

I'm requesting access to (please check one):

- View Records Only Obtain Copies of Records

Please complete the following information:

Form with fields: Date(s) of service associated with request, Reason for request, Describe the information you are requesting to view or obtain copies of

I certify that this request to access health information is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that Centura Health may not be able to grant me access to certain types of health information and information belonging to minors between the ages of 13-17 will not be accessible to ensure compliance with legal requirements regarding access to patient records. I understand that if I need to obtain hard copies there may be a charge associated with such copies.

Signature of Patient/Legal Representative: _____ Date: _____ Time: _____

If Legal Representative, Print Name: _____ Relationship to Patient: _____

Form with fields: Centura Health Use Only: Individual Who Received Request, Date Request Received, Verification of Identity, Medical Record #, Request Approved/Denied, Date Fulfilled, Patient Acknowledgement of Inspection, Reason for Denial

PSYCHIATRIC RECORD PHYSICIAN APPROVAL: I am the attending physician for the above named patient. I have reviewed the medical record(s) to determine if they contain information relative to psychological or psychiatric problems which, if revealed to the patient is reasonably likely to endanger the life or physical safety of the individual or another person.

These portions of medical record(s): May be released to the patient May NOT be released to the patient

Signature of Physician or Designee: _____ Date: _____ Time: _____

Print Name of Physician: _____