Patient Request for Health Information

Patient Information (Please Print)

Last Name:	First Name:		Middle Initial:
Name at Time of Treatment (if different from above):	MRN:		FIN:
Date of Birth (MM/DD/YYYY):	Phone:		
Street Address:	City:	State:	Zip:

Requesting Information from (**specify Shriners Hospitals for Children Facility**):_____

☐ Date(s) of treatment: Specific dates:
_____/_____/_____ through _____/_____/_____

☐ Abstract (Includes All Listed Documents except Radiology Images)	☐ Progress/Clinic notes
☐ Discharge Summary	☐ Consultation reports
☐ History & Physical	☐ Radiology reports
☐ Operative report	☐ Radiology images/CD
☐ Laboratory reports	☐ Other: _____

In what format would you like to receive your records? (**choose one**):
☐ Paper ☐ Thumb Drive ☐ *Email ☐ Other (specify):_____

**Email is not a secure means of communication. We will encrypt email communications of your records.

☐ **Please send copies of my records to:** ☐ Self ☐ Parent/Legal Guardian or other Personal Representative (A person with **legal authority** to make health care decision on behalf of the individual for example Power of Attorney or Living Will):
Name: _____
Street Address: _____
City/State/Zip code: _____
Phone number of individual receiving records if not patient: _____
Email address (print clearly): _____
Fax Number (print clearly):_____

I understand that information contained in my medical record may contain HIV/AIDS testing, results, and/or treatment records; mental health diagnosis and/or treatment records; alcohol and/or drug abuse diagnosis and/or treatment records.

Processing Your Requested Information:
There may be a fee for copies of requested health information. We will inform you of the fee before providing the requested copies. We will respond to your request within 30 days from the date of receipt. Actual turnaround time is typically shorter. We may require an additional 30 day extension if your health information is not readily accessible or is maintained in an offsite storage facility. We will notify you if we need this extension of time.

***Please include a copy of photo ID with signature for verification purposes.**

_____AM/PM _____
Signature of Patient/Parent Legal Guardian **Date/Time** **Relationship to Patient**

_____
Printed Name

Patient Request for Health Information Shriners Hospitals for Children®

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Patient Information Label Information