Saint Michael's Medical Center

Medical Record Request Form

- ☐ Authorized person will pick up
- ☐ Mail to Authorized person
- ☐ Fax to Authorized person

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of Patient: ______________________ (first) ______________________ (last)

Date of Birth: ______________________ SSN: ______________________

Patient's Address: ____

City: ______________________ State: __________ ZIP: __________

Phone (cell): ______________________ (home): ______________________

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize *Saint Michael's Medical Center*
to release to (Persons/Organizations authorized to receive this information)

Name of Authorized Person/Organization: ______________________

Address: ______________________ City: __________ State: __________ Zip: __________

Phone: ______________________ Fax: ______________________

☐ Covering the period of healthcare from ______________ to ______________

Please check the following information requested:

☐ All health information pertaining to my medical history, mental or physical condition, and treatment received. **–OR-**

☐ Only the following records or types of health information (including any dates):

- ☐ Discharge Summary
- ☐ History and Physical Rehab
- ☐ Rehab
- ☐ Consultations(s)
- ☐ Operative Report
- ☐ ER
- ☐ All pertinent Lab/X-rays/EKG
- ☐ Other: ______________

☐ I specifically authorize release of the following information (initial as appropriate):

- ☐ Mental Health Treatment Information
- ☐ HIV test results
- ☐ Alcohol/drug treatment Information
- ☐ Outpatient psychotherapy notes
- ☐ STD
- ☐ Sexual Assault
- ☐ Child Abuse/Neglect

PURPOSE

Purpose of requested use of disclosure: ☐ Patient request **-OR-** ☐ other

EXPIRATION

This authorization expires on: ______________________________

2 HIMR01

PATIENT I.D.