PATIENT ACCESS TO MEDICAL INFORMATION

This form permits you to obtain a copy of or inspect your health information from King's Daughters, its Family Care Centers, Medical Specialties and Urgent Care Centers. This form also permits you to direct a copy of your health information to a person you designate, if you choose.

1. Who is the patient?

Name _____

Date of Birth _____ Phone number_____

Mailing Address _____

2. What information would you like to request?

- ☐ Records beginning on (date): _____
- ☐ Emergency Room visit (Date)_____
- ☐ Hospital stay: From _____ To_____
- ☐ Radiology reports only ☐ MRI ☐ X-ray ☐ CT scan ☐ Ultrasound ☐ Other
- ☐ Radiology reports and discs/images ☐ MRI ☐ X-ray ☐ CT scan ☐ Ultrasound ☐ Other
- ☐ Laboratory results
- ☐ Demographic sheet
- ☐ Entire medical record for all your hospital visits. (25 years)
- ☐ HIV/AIDS testing and results, genetic information, and STDs (you must check this box if you want this information to be part of the request)
- ☐ Substance abuse, psychiatric records (you must check this box if you want this information to be part of the request).
- ☐ Other: Please describe: _____

3. Who is to receive the requested information?

- ☐ Picked up by you in person
- ☐ Picked up by someone you choose. If yes, who? _____
- ☐ Mailed to your home (address above will be used unless notified)
- ☐ I am requesting a copy be made available to the following person or entity: (please specify the recipient's name and address)_____
- ☐ By encrypted email (Files exceeding a certain size may not be available for email).
  Email address _____
- ☐ By unencrypted email ***Note**: if you select this option there is a risk that the records could be read or accessed by someone else during transmission.* _____

4. What format are you requesting?

- ☐ Paper copy
- ☐ Electronic copy (records will be provided on a CD unless email is requested).

- I understand that information made available to a person or entity I designate may no longer be confidential or protected by privacy laws and may be subject to re-disclosure by the recipient.
- KDMC will rely on this request to make this information available as outlined above and cannot be held liable for any information released on my request.
- This form expires when the records have been released or viewed.

Signature _____Date_____

Patient or Legal Representative (Proof of representation required)

Relationship, if not patient _____