HENDRICK HEALTH

ROI

Patient Information (Please Print)

First Name: Middle Initial: Last Name:

Name at Time of Treatment (if different than above):

Date of Birth (MM/DD/YYYY): Phone: E-mail (optional):

Street Address: City: State: Zip:

Requesting records from: (*Check Location/s) _____ HMC _____HMCS _____ HMCB _____Other (List Below)

Facility Name:	**Facility Name:**
Address:	**Address:**
City/State/Zip:	**City/State/Zip:**

What records do you want to receive or have disclosed to the recipient noted? (Check appropriate boxes below):

Date(s) of Service:_____through_____

☐ Progress Notes ☐ Emergency Room Record ☐ Discharge Summary ☐ History and Physical
☐ Consultation(s) ☐ Lab Reports ☐ Pathology Reports ☐ Operative Note(s) ☐ Billing Records
☐ Imaging/X-Ray Reports ☐ Entire Record ☐ Fetal Heart Monitor Strips ☐ Imaging Diagnostic Studies/CD/Media
☐ Other (specify)_____

If it exists, please select the following "Sensitive Information" that can be disclosed with this release request:

☐ Alcohol Abuse ☐ Drug Abuse ☐ Communicable diseases, including HIV status
☐ Genetic Testing ☐ Psychiatric/Behavioral Diagnoses

How would you like your records delivered?

☐ Paper
☐ Electronic: ☐ Email (I understand that there is a risk to me when my information is transmitted via an unsecured e-mail system, and the information could be accessed by a third party during the transmission process. By checking the box to request Email delivery I accept this risk.)
☐ USB or CD
☐ Password Protected ☐ Not Password Protected
☐ Mail to address below ☐ I will pick up in person

If mailing, where do you want the information sent? (Fill in boxes below):

Please provide my records to: ☐ Myself ☐ Personal Representative (indicated below) ☐ Other Third Party (indicated below)

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (if applicable):

Name of Patient or Personal Representative (please print)	**Relationship (please print)**

Patient or Legal Representative Signature		Date/Time
Relationship to Patient / Authority to Act on Patient's Behalf	Interpreter if Utilized	Date/Time
Witness Signature		Date/Time

This Healthcare Facility recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records, if not produced in an electronic format.

Release of Health Information

***Hendrick Medical Center (HMC) Hendrick Medical Center South (HMCS) Hendrick Medical Center Brownwood (HMCB)**