

Patient Name _____ DOB _____

I am requesting the following information to be released to me or my designee.

Release information to:

Name _____ Phone _____

Address _____ City _____ State _____ Zip Code _____

Email _____

Please check the following:

I understand that the protected health information (PHI) I am requesting may include disclosure of information regarding HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse or mental illness. I authorize the release or disclosure of this information unless I check the box below. Please note that this form **will not** be used to disclose psychotherapy PHI. I do **NOT** want any information relating to:

HIV/AIDS, sexually transmitted disease, drug and/or alcohol or mental illness disclosed.

Please release the following (check all that apply):

Clinic Records* Labs Radiology Reports/Films Hospital Records* All Medical Records

Recent 2 years of physician reports, labs, x-rays and special tests Other (Specify): _____

For Billing records, please contact our billing department at 1-888-292-8810.

NOTE: SPMC will provide the patient with the past two years' worth of records unless otherwise stated below.

Date of Service: _____

Format you like your protected health information in. (select from the options below)

Paper Copy

Mail

Electronic Copy (CD-ROM)

Mail

Electronic Delivery (Fax/Email)

Fax

Email

NOTE:

I acknowledge that the delivery of my Protected Health Information sent via email may not encrypted or secure.

Patient Signature

Date

Summit Pacific Medical Center Use Only

Notes

ID verified Yes No Initials _____ Date _____