SUMMIT PACIFIC
• MEDICAL CENTER •

Patient Request Form

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	Electronic Copy (CD-ROM)	Electronic Delivery (Fax/Email)
☐ Mail	☐ Mail	☐ 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 _____