## **PATIENT ACCESS FORM**

Section A: This section must be completed	l for all requ	ests for a	access				
Patient Last Name		Fir	First Name MI				
Date of Birth		So	Social Security Number (optional):				
Address:		I					
City:			State:			Zip:	
Phone Number:			Email Address:				
Name at time of treatment, if different	than above	<b>e</b> :					
Name and address of health provider	or entity w	ho will p	provide you with acce	ess to this	informatio	n:	
Where do you want the information se	ent? Self	or Per	sonal Representative	e (indicated	d below)		
Personal Representative Name:							
Address:							
City:			State:				
Phone Number:			nail Address:		<u> </u>		
Fax Number:							
What records are you requesting?	1			I	1		
What records are you requesting?  Description:	Date(s):	Descript	tion:	Date(s):	Description	);	Date(s):
	Date(s):	Disc Proo	charge Summary gress Notes al Evaluation nized bill ory and Physical exam	Date(s):	Description Other: Other: Other:	<i>:</i>	Date(s):
Description:  ☐ All Protected Health Information in medical record ☐ Admission form ☐ Physician orders ☐ Medication Sheets		☐ Disc ☐ Proc ☐ Initia ☐ Item ☐ Histo ☐ Rad	charge Summary gress Notes al Evaluation nized bill ory and Physical exam liology Reports	Date(s):	Other:	:	Date(s):
Description:  All Protected Health Information in medical record Admission form  Physician orders Medication Sheets Lab Tests		☐ Disc ☐ Proc ☐ Initia ☐ Item ☐ Histo ☐ Rad	charge Summary gress Notes al Evaluation nized bill ory and Physical exam liology Reports	Date(s):	Other:	<i>:</i>	Date(s):
Description:  All Protected Health Information in medical record Admission form  Physician orders Medication Sheets Lab Tests	`medical reco	Disc	charge Summary gress Notes al Evaluation nized bill ory and Physical exam liology Reports		Other: Other: Other:		
Description:  ☐ All Protected Health Information in medical record ☐ Admission form ☐ Physician orders ☐ Medication Sheets ☐ Lab Tests  Please describe the exact nature and dates of Preferred method of delivery: ☐ secure em	medical reco	Disc	charge Summary gress Notes al Evaluation nized bill ory and Physical exam liology Reports you would like.		Other: Other: Other:		
Description:  ☐ All Protected Health Information in medical record ☐ Admission form ☐ Physician orders ☐ Medication Sheets ☐ Lab Tests  Please describe the exact nature and dates of ☐ Preferred method of delivery: ☐ secure em ☐ Other electronic method (USB, CD, other	medical reco	Disc	charge Summary gress Notes al Evaluation nized bill ory and Physical exam liology Reports you would like.		Other: Other: Other:		
Description:  ☐ All Protected Health Information in medical record ☐ Admission form ☐ Physician orders ☐ Medication Sheets ☐ Lab Tests  Please describe the exact nature and dates of ☐ Preferred method of delivery: ☐ secure em ☐ Other electronic method (USB, CD, other	medical reco	Disc	charge Summary gress Notes al Evaluation nized bill ory and Physical exam liology Reports you would like.  ck up of paper copies		Other: Other: Other:		
Description:  ☐ All Protected Health Information in medical record ☐ Admission form ☐ Physician orders ☐ Medication Sheets ☐ Lab Tests  Please describe the exact nature and dates of ☐ Other electronic method (USB, CD, other please print your name and sign	medical reco	Disc	charge Summary gress Notes al Evaluation nized bill ory and Physical exam liology Reports you would like.  ck up of paper copies	☐ fax ☐	Other: Other: Other:		
Description:  ☐ All Protected Health Information in medical record ☐ Admission form ☐ Physician orders ☐ Medication Sheets ☐ Lab Tests  Please describe the exact nature and dates of ☐ Other electronic method (USB, CD, other please print your name and signs)  Name of Patient or Personal Research	medical reconstant mail mainstry. Please spen below:	Disc	charge Summary gress Notes al Evaluation nized bill ory and Physical exam liology Reports you would like.  ck up of paper copies [	☐ fax ☐	Other: Other: Other:		
Description:  ☐ All Protected Health Information in medical record ☐ Admission form ☐ Physician orders ☐ Medication Sheets ☐ Lab Tests  Please describe the exact nature and dates of ☐ Other electronic method (USB, CD, other please print your name and sign	medical reconstant mail mainstry. Please spen below:	Disc	charge Summary gress Notes al Evaluation nized bill ory and Physical exam liology Reports you would like.  ck up of paper copies	☐ fax ☐	Other: Other: Other:		

Select Medical recognizes a patient's rights under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.