PATIENT REQUEST FOR ACCESS/COPY OF MEDICAL RECORDS

Did you know you can view most of your medical record online via MyAtriumHealth? Go to www.atriumhealth.org and click on MyAtriumHealth. If you would like a copy of your medical record please complete the form below.

I am a patient of Atrium Health and my information is listed below:

Patient Name: _____ Date of Birth: _____

Street Address: _____ City, State, Zip: _____

Telephone: _____ Email address: _____

By providing your email address, you acknowledge and accept the risks outlined in Guidelines for Electronic Communications, posted on atriumhealth.org.

I would like for _____ **to (choose one):**

(list name of facility or practice)

☐ **give me a copy of my health information**

☐ **send a copy of my records to OR share my health information with:**

_____

(Name of Facility, Person, Company) (Street Address or PO Box, City, State, Zip Code)

_____

(Phone Number) (Fax Number)

_____

(E-mail Address)

I would like these dates of service to be sent/shared: _____

I want the parts of my record checked below sent/shared:

Medical Records (check all that may apply):	**Imaging (requires CD format):**	**Billing:**
☐ Facility Summary (includes items in **bold**) ☐ **Discharge Summary** ☐ **History and Physical** ☐ **Consultation Reports** ☐ **Office/Home Visits** ☐ **Emergency Record** ☐ **Operative Reports** ☐ **Laboratory Reports** ☐ **Pathology Reports** ☐ **Radiology/X-Ray Reports** ☐ **Immunizations** ☐ Therapy Notes (Occupational/Physical/Speech) ☐ Sleep Study Reports ☐ Entire Medical Record (Does not include billing or imaging) ☐ Other: _____	☐ Radiology Images ☐ Cardiology Images (Echo, Cath Lab) ☐ Neurology Images (EEG) ☐ OBGYN Ultrasound ☐ Other Imaging: _____	☐ Itemized Bill(s) ☐ UB04 Form ☐ CMS 1500 Form ☐ Other Billing: _____

I want these records as a/an (choose one):

☐ **CD**

☐ **E-mail**

☐ **Paper copy**

☐ **Other:** _____

I want you to (choose one):

☐ **Mail them**

☐ **Send them secure e-mail**

☐ **Fax them to:** _____

☐ **Prepare them to be picked up at:** _____

☐ **Share my health information verbally**

As an alternative you may schedule an appointment with your healthcare provider's office to see your record in person. Please note it may take up to 30 days to schedule the appointment or provide copies.

Signature: _____ **Print Name:** _____

Relationship to Patient: _____ **Date:** _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this for the patient. (Written proof may be requested.)

Note: If minor consented to a licensed physician for their treatment for pregnancy, sexually transmitted disease, outpatient behavioral/mental health, or outpatient treatment of controlled substances or alcohol without parental consent, the minor must sign this authorization. When the patient is a minor being treated for a substance use disorder and the parent or guardian consented for such treatment, both the minor and parent or guardian must sign this authorization.

Signature of Minor: _____ **Print Name:** _____ **Date:** _____

Date records given/sent to patient: _____ via ☐ Mail ☐ Fax ☐ Other _____ ☐ **ID Verified** ☐ **DL/OtherID** _____

Atrium Health Teammate Name & Department _____ **Date:** _____ **# of Pages** _____

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Atrium Health

Place Patient Label Here