

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

I understand the information to be disclosed may include information regarding genetic testing, genetic services and family medical history, mental health/developmental disabilities, Substance Use Disorder, HIV Test results, and AIDS/AIDS-related illness.

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 _____

Rev. July 2024



Atrium Health

Place Patient Label Here