

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 E-mail with Patients](#), posted on carolinashealthcare.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:

Facility (check all that may apply): <input type="checkbox"/> Facility Summary (includes items in bold) <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Record <input type="checkbox"/> History and Physical <input type="checkbox"/> Operative Reports <input type="checkbox"/> Laboratory reports <input type="checkbox"/> Radiology/X-Ray Reports <input type="checkbox"/> Therapy Notes <input type="checkbox"/> Other _____ <input type="checkbox"/> Entire record <input type="checkbox"/> Itemized Bill	Office/Clinic/Home Care (check all that may apply): <input type="checkbox"/> Office/Clinical Summary (includes items in bold) <input type="checkbox"/> Office/Home Visits <input type="checkbox"/> Physical Exam <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Therapy Notes <input type="checkbox"/> Other _____ <input type="checkbox"/> Entire Record <input type="checkbox"/> Itemized Bill
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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 by: _____
 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.)

Date records given/sent to patient: _____ via Mail Fax Other _____ ID Verified DL/OtherID _____
Atrium Health Teammate Name & Department _____ Date: _____ # of Pages _____

