O O O O O

Patient Name: _____ DOB: _____ LAST 4 DIGITS SSN: _____

Address: _____

I, the patient (or legal representative of the patient), am requesting that CaroMont Health:

☐ Give my medical records to me ☐ Give my medical records to someone else, listed below ☐ Obtain my records from, listed below:

Name & Address: _____

_____

Information to be provided: Date(s) of Service: _____

____ Abstract (Discharge Summary, History/Physical, Consultation Reports, Operative Reports, Labs, Radiology, Pathology Report, EKG's)

____ Entire Record ____ER Record ____Discharge Summary ____History & Physical ____Consultation Reports ____Operative Reports

____Physician Orders ____Progress Notes ____Pathology Report ____Autopsy Report ____Nursing Data/Notes ____Laboratory Reports

____Radiology Results ____Radiology Images on a CD ____Other (please specify) _____

I am requesting the records be provided in the following method/format: ☐ Paper **OR** ☐ Electronic (Check specifics below)

Paper:

____In-Person Pickup

____Mailed to address above or other address provided below:

_____

_____

NOTE: Please consider the method you wish to receive or have your records sent if using an electronic method.

- Information placed on an unsecured CD (without password) is not secure and could result in information being read or accessed while in transit or by anyone who accesses the CD. A secured CD (with password) can only be opened by someone who has the password.
- Information sent by fax can be accessed by any person physically on the receiving side of such fax transmission and is not secured.
- E-Mail may require a password to access a file sent depending on the security of the recipient's e-mail server.

FEES: A flat fee of $5.00 may be charged if records are released on a CD. No fees are charged if released by any other method.

Electronic (pdf format will be used unless otherwise specified)**:**

____Release records to my MYCHART account

____CD with password OR _____CD without password

____In-Person Pickup (password provided when picked up)

____Mail CD to address above or other address provided below:

_____

_____

___E-mail CD password to: _____
___Mail CD password to above address separately

____E-Mail PDF file _____securely or _____unsecurely to:

_____

____Fax records to this number:

_____

If I am requesting access to or directing release of medical records for a minor patient, I certify that I have the legal authority to access or direct release of the minor patient's medical records.

Healthcare POA's, Executors of Estates, and other Court authorized Legal Representatives will be asked to provide the documentation of their legal relationship to the patient.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient or Legal Representative Relationship of Legal Representative to Patient (Healthcare POA, Executor, etc.)

CaroMont Staff Use Only for Verification Processes MRN: _____

Face-to-Face Request: _____
Patient/Authorized Legal Representative identification verified:
____ Drivers' License / Other Photo ID (Do not copy photo identification)
____ Signature matched with file in the medical record
Employee's Initials: _____

Verbal or Phone Request (release to patient or for Continuing Care): _____
____ Patient Name + 2 Identifiers verified with patient (DOB, Address, SSN)
Staff should complete form and scan into the Release.
Employee's Initials: _____