



Patient Sticker Or	MR#:
	Acct#:

Patient Access Request

Patient Name: _____

Date Of Birth: _____

Address: _____

Phone Number: _____

Street

City

Zip

1) I authorize St. Elizabeth _____

(Medical Center / Medical Group Site)

Internal Use Only:	<input type="checkbox"/> Pick Up	<input type="checkbox"/> Mail
<input type="checkbox"/> FOC (proof obtained)	<input type="checkbox"/> Request to Physician	
<input type="checkbox"/> Extended Release	<input type="checkbox"/> See Distributee Form	

<input type="checkbox"/> TO RELEASE this patient's information to	<input type="checkbox"/> TO OBTAIN this patient's information from
	<input type="checkbox"/> Patient Being Seen Right Now
	➔ Fax records to # _____
	➔ To the Attention of: _____
Name: _____	
Address: _____	
City/State/Zip Code _____	
(Area Code) Phone: _____	(Area Code) Fax Number: _____

2) Description of information that may be disclosed (check off the appropriate items):

Date(s) of Service: _____

- Abstract of Hospital Record (ED/dictations/tests)
- Entire Medical Record
- Labs / Radiology (Films must be requested from the Radiology Dept. directly)
- History & Physical / Op Report / Discharge Summary
- Emergency Dept. Record
- Immunization Records
- Confined to records regarding the following medical condition/injury: _____
- Other (please describe) _____

* Specific authorization is required to release the following documentation. If authorizing release, please check and initial

- _____ Substance Abuse Records (initial)
- _____ Psychiatric Records (initial)
- *HIV (requires separate NYS release form, please ask for assistance)

3) Media Type: CD Paper

4) Optional Extended Release: _____ I authorize the release of future healthcare visits generated/created within _____
(initial) months after the date of signature on this release.

5) I understand that: • By signing this form I am authorizing the release of my medical records • I can request a copy of this form • I may be charged for labor, shipping, and supply costs • I may revoke this authorization in writing at any time by completing the bottom of this form or by contacting the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. This authorization expires on: _____ (insert applicable date or event), or within 1 year of the date of the authorization, whichever is greater.

6) Date: _____ Time: _____ Signature of Patient/Legal Representative: _____

(DO NOT SIGN A BLANK FORM)

If Legal Representative, relationship to patient: _____

Date: _____ Time: _____ Signature of Language Interpreter (if Applicable): _____

REVOCAION *I am revoking this authorization and no longer authorize records to be released as of the date below.		
Date: _____	Time: _____	Signature of Patient/Legal Representative: _____
Date: _____	Time: _____	Witness Signature: _____