Patient Request for Health Information

Patient Information:

First Name: _____ MI_____Last Name: _____

Previous Name (if applicable): _____

Address: _____ City, State, Zip: _____

Phone Number: (_____)_____ Date of Birth: _____/_____/_____

I would like records from this specific Hospital, Clinic, or Provider:

Hospital, Clinic, Provider:_____

Date(s) of Service: _____/_____/_____ through _____/_____/_____ (if not specified, most recent will be sent)

Information Requested:

___ History and Physical ___ Pathology Reports ___ Radiology Reports ___ Discharge Summary

___ Consult Reports ___ Emergency Room Notes ___ Laboratory Reports ___ Progress Notes

___ Operative/Procedure Notes ___ Assessment/Evaluation ___ Immunizations ___ Other (please specify below):

Other: _____

Format Requested:

_____ Paper _____ CD _____ My Chart (if you do not have an account, please visit www.scbh.org)

_____ E-mail _____

(By Choosing this option, I acknowledge there may be security risks to my health information in transit)

I would like my records sent to:

Name: _____

Address: _____

City, State, Zip: _____

E-mail address (If requested format): _____

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____

Printed Name **Relationship to Patient**