Sanitas	DEPARTMENT: HEALTH INFORMATION MANAGEMENT	Policy #: HIM 8.004 Attachment B
	Effective Date: 12/22/2023	Revised Date: Initial

Title: Patient Access to Medical Records

***For the request of an <u>entire medical record</u>, you will need to complete a different form. Please ask for an "Authorization for Disclosure of Medical Records" form (HIM Policy 8.004; Attachment A)**

Patient Information *{Please Print)*

First Name | Middle Initial | Last Name

Date of Birth (MM/DD/YYYY) | Phone | Email

Disclose To:_____

Purpose of Disclosure: ☐ Continuity of Care ☐Treatment ☐ Personal Use

Indicate the type of information to be disclosed:

☐ All Medical Records ☐ Immunizations

☐ Progress Note- Date of Visit: _____

☐ Test Results (Diagnostic Imaging, Lab/Pathology)

Type of Test: _____ Test Date: _____

How would you like your information/records delivered?

☐Mail ☐ Pick Up ☐ Emailed

I understand that by checking to receive my Medical Records through mail or email, it is not the responsibility of Sanitas Medical Center if records are misdirected.

I certify that I am the patient, or the patient's representative, and authorized to request and receive Protected Health Information for the above-named individual:

Print Name of Patient or Representative

Print Relationship *(If applicable)*

Signature of Patient or Representative

Date