Patient Request for Access (Outgoing)

Patient Name (print) _____

Patient Address _____

_____

Telephone: _____ **Date of Birth:** _____

***I understand there may be a charge for records that are for personal use if over 15 pages _____ (patient initials)**
I Request My Records be Sent to:
Provider Name:_____
Office Name and Address_____

Office Phone: _____ ***Office Fax:*** _____
***Please be specific on what records you need released (office notes, diagnostics, specific provider, all records, etc).**

_____

____ Records are for my personal use. Please mail to my address noted above, or as otherwise indicated:

____ Records to be sent electronically: _____(email) or Picked up at HIM _____
EMAILS MAY ONLY BE SENT TO PATIENTS PERSONAL EMAIL AND WILL ARRIVE VIA OUR COPY SERVICE CIOX Health SECURE PORTAL

This document is provided for reference purposes of the disclosure. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.
This request expires 60 days from the date of signing. You may revoke this request at any time by sending written notification to the Privacy Officer, South Bend Clinic, 211 N. Eddy Street, South Bend IN 46617. Your notice will not apply to actions taken by the requesting person prior to the date they receive your written request to revoke authorization. I understand there may be a fee for copying these records or obtaining digitized diagnostics. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
I understand that my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. ( ) Initial if ok to release

I request South Bend Clinic to release the above noted patient health information:

_____ _____
Signature of Patient or Personal Representative **Date**

_____
Description of Personal Representative's Authority

Office use only: **Signature of Witness/Employee** _____ **Medical Record #** _____

_____ Patient had appropriate identification **_____ Patient is known to me** **_____ Verification of Personal Representative's Authority**

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