AXISHealth System

Patient Request to Access Health Records Form

Patient Name:			
Address:			
City, State, Zip Code:			
Phone Number:			
Date of Birth:		**Last 4 of Social Security #**	

I am requesting access to (please check one): ☐ Obtain Copies of Health Records ☐ View Records Only

Treatment Dates:	
Type of Information:	☐Primary Care ☐Mental Health/Psychiatric ☐Substance Use ☐Family Planning/Contraception ☐Dental
Delivery Instructions: **(Choose One)**	☐ Paper (☐ Mail to address above or ☐ Call to pick up) ☐ Fax (number: _____) ☐ Email (password protected) email address: _____ ☐ CD (password protected) (☐ Mail to address above or ☐ Call to pick up)
Documents/Information Requested:	☐ Attendance ☐ Balance/Payment ☐ Diagnostic Evaluation/Assessment Update ☐ Discharge Summary ☐ Encounter/Progress Notes or Visit Notes ☐ Immunizations ☐ Lab Results ☐ Medications ☐ Problem List ☐ Service History ☐ Treatment/Service Plan ☐ Entire Record ☐ Other: _____ _____

I certify that this request to access my health information is made voluntarily and the information given above is accurate to the best of my knowledge. I understand that Axis Health System may not be able to grant me access to certain types of health information. Requests for Mental Health and Substance Use Disorder information belonging to minors (ages 15-17) and Family Planning/Contraception (any age minor) must be signed by the minor patient to ensure compliance with legal requirements regarding access to patient records. I understand a fee may be charged for copies of my health records.

_____ _____

Patient Signature (*Representative/Parent/Legal Guardian) Date

*By signing as the Representative/Parent/Legal Guardian, I am representing that I have legal authority to do so and that my ability to sign on behalf of the patient has not been limited or restricted either voluntarily or through legal process. Verification of legal documents may be requested.

_____ _____

Name of Individual Signing on Patient's Behalf Relationship to Patient

HIM Use Only

Signature Verification: ☐ Driver's License ☐ Other Appropriate ID or previously signed document in chart ☐ Unable to verify

MENTAL HEALTH/PSYCHIATRIC RECORD PROVIDER APPROVAL: I am the primary psychiatric or mental health provider for the above-named patient. I have reviewed the health record(s) to determine if they contain information relative to problems which, if revealed to the patient, is reasonably likely to endanger the life or physical safety of the individual or another person.

Psychiatric portions of the health record(s): ☐ May be released to the patient ☐ May **NOT** be released to the patient based on 45 CFR § 164.524(a)(3)(i-iii)

Signature of Psychiatric Provider: _____ Date: _____
Print Name: _____

Mental health portions of the health record(s): ☐ May be released to the patient ☐ May **NOT** be released to the patient based on 45 CFR § 164.524(a)(3)(i-iii)

Signature of Mental Health Provider: _____ Date: _____
Print Name: _____

Patient# _____

Authorized 7.1.17