

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): <input type="checkbox"/> Obtain Copies of Health Records <input type="checkbox"/> View Records Only																	
Treatment Dates:																	
Type of Information:	<input type="checkbox"/> Primary Care <input type="checkbox"/> Mental Health/Psychiatric <input type="checkbox"/> Substance Use <input type="checkbox"/> Family Planning/Contraception <input type="checkbox"/> Dental																
Delivery Instructions: (Choose One)	<input type="checkbox"/> Paper (<input type="checkbox"/> Mail to address above or <input type="checkbox"/> Call to pick up) <input type="checkbox"/> Fax (number: _____) <input type="checkbox"/> Email (password protected) email address: _____ <input type="checkbox"/> CD (password protected) (<input type="checkbox"/> Mail to address above or <input type="checkbox"/> Call to pick up)																
Documents/Information Requested:	<table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Attendance</td> <td><input type="checkbox"/> Medications</td> </tr> <tr> <td><input type="checkbox"/> Balance/Payment</td> <td><input type="checkbox"/> Problem List</td> </tr> <tr> <td><input type="checkbox"/> Diagnostic Evaluation/Assessment Update</td> <td><input type="checkbox"/> Service History</td> </tr> <tr> <td><input type="checkbox"/> Discharge Summary</td> <td><input type="checkbox"/> Treatment/Service Plan</td> </tr> <tr> <td><input type="checkbox"/> Encounter/Progress Notes or Visit Notes</td> <td><input type="checkbox"/> Entire Record</td> </tr> <tr> <td><input type="checkbox"/> Immunizations</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Lab Results</td> <td></td> </tr> </table>			<input type="checkbox"/> Attendance	<input type="checkbox"/> Medications	<input type="checkbox"/> Balance/Payment	<input type="checkbox"/> Problem List	<input type="checkbox"/> Diagnostic Evaluation/Assessment Update	<input type="checkbox"/> Service History	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Treatment/Service Plan	<input type="checkbox"/> Encounter/Progress Notes or Visit Notes	<input type="checkbox"/> Entire Record	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Lab Results	
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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. Electronic signatures are not accepted.

 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# _____