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 ☐Dental		
Delivery Instructions: **(Choose One)**	☐ Paper - Mail to address above or other address: _____ _____ ☐ Paper - Call to pick up _____ ☐ Fax: _____ ☐ Email (encrypted): _____		
Documents/Information Requested:	☐ **Pertinent Health Records Only**: Encounter/Progress Notes, Diagnostic Evaluation/Assessment Update, Discharge Summary, Treatment/Service Plan, Laboratory/Pathology/Radiology/ Diagnostic Reports Or Specific Documents: ☐Attendance ☐ Treatment/Service Plan ☐ Entire Record ☐Billing Records ☐ Immunizations ☐ Problem List ☐Diagnostic Evaluation/Assessment Update ☐ Lab Results ☐ Other: _____ ☐Discharge Summary ☐ Medications _____ ☐Encounter/Progress Notes or Visit Notes _____		

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

*I have legal authority to sign on behalf of the patient; my ability has not been limited/restricted 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: _____

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