FOR SYSTEM STAFF ONLY
COPY SENT ON: _____ _____
Date Initials

TO BE COMPLETED BY SYSTEM STAFF
Medical Record # _____
CSN#_____

Edward-Elmhurst Health
PATIENT REQUEST TO OBTAIN MEDICAL RECORDS

1. **Patient information**

Patient's Legal Name:	Date of Birth:	Telephone Number:
Street Address:	City, State, Zip Code:	
Approximate dates of treatment* (*Must be completed)		

2. I request access to the following information (check applicable box(es)):

- ☐ Emergency Record
- ☐ Immediate Care/Walk-in Clinic
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultations
- ☐ Immunizations
- ☐ Report of Operation
- ☐ Pathology Report
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Chemical Dependency Assessments
- ☐ BH Level of Care Assessments
- ☐ Psychiatric Evaluation
- ☐ Psychological Testing
- ☐ Psychosocial Assessment
- ☐ Cardiac Catheterization Report
- ☐ EKG/EEG/Echo Reports
- ☐ Radiology CDs or Films
- ☐ Physical Therapy, Occupational Therapy or Speech Therapy
- ☐ Physician Office Medical Record
- ☐ Corporate Health/Workers Comp
- ☐ Abstract Copy (Tests, Results, and Typed Reports)
- ☐ Medication List
- ☐ Billing Statement
- ☐ Complete Copy
- ☐ Other: _____

3. From the entity(ies) identified below. (Check all that apply).

- ☐ Edward Hospital
- ☐ Elmhurst Memorial Hospital
- ☐ Linden Oaks Hospital
- ☐ Edward Medical Group
- ☐ Linden Oaks Medical Group
- ☐ Elmhurst Medical Group
- ☐ Elmhurst Memorial Primary Care Associates
- ☐ Elmhurst Clinic
- ☐ Elmhurst Medical Associates

4. **Request to Send to Third Party:** If this information is not being sent to me, then deliver to the Person/Entity identified below.

Name of Person/Entity and Relationship:	Telephone Number:
Street Address:	Fax Number:
City, State, Zip Code:	

5. **Method of disclosure:**

- ☐ Copy of Record – Mailed to address specified
- ☐ CD - Mailed to address specified
- ☐ Physician Fax
  Fax Number: _____

Released electronically:

- ☐ Email/Electronic Delivery (see page 2)

EMAIL/ELECTRONIC DELIVERY NOTICE: I understand Emails can be intercepted, altered, forwarded, or used without authorization or detected. Emails can be circulated, forwarded and stored in both electronic and paper formats. Email addresses can be incorrectly written or typed. Emails can be inadvertently exposed, lost during creation and transmission due to technical failure. I understand and accept the risk using an unsecure email. I agree for Edward Elmhurst Health and/or ScanSTAT Technologies to email me my protected health information when the email delivery method is chosen and I fully understand the risk involved in using the email delivery method.

*PLEASE SIGN IF YOU AGREE AND AKNOWLEDGE*_____

PLEASE PRINT CLEARLY AN EMAIL ADDRESS FOR ELECTRONIC DELIVERY:

_____

PLEASE PROVIDE A PREFERED PASSWORD MUST CONTAIN 8 TO 12 CHARACTERS

☐☐☐☐☐☐☐☐☐☐☐☐

_____

Signature of Patient or Legally Authorized Representative *Date*

_____

Printed Name of Patient or Authorized Representative that Signed above

_____

If not Patient, describe relationship of Legally Authorized Representative to Patient (This section must be completed.)

_____ _____

*Signature of Minor Patient**** *(Printed Name of Minor)* *Date*

_____ _____

*Signature of Witness** *(Printed Name of Witness)* *Date*

*****Minor Patients:** *If the patient is 12-17 years of age and the patient's parent/legal Guardian/Representative is requesting patient's mental health records, the signature of the minor patient is also required, and a witness signature is required.*

(ONLY if releasing mental health records on a 12-17 year old patient to a guardian or other legal representative)