MHC Healthcare
Quality healthcare with a heart!

Medical Records Request

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

I authorize the custodian of records of (provider/entity): _____

Address: _____

Phone/Fax: _____

Please send the records listed above to:

Name: _____

Address: _____

Phone/Fax: _____

Purpose of Request:

☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Disability

☐ Transfer/Reason: _____

Information To Be Released

☐ Please provide a 2 year abstract of my records
($15.00 Flat Copy Fee, plus $0.25 per page)

☐ Please provide my entire medical record for dates:

From: _____ To: _____
($15.00 Flat Copy Fee, plus $0.25 per page)

☐ Other – be specific: include Clinic/Diagnostic treatment type and dates, ED Visit date, and/or Inpatient

☐ Title XIX patients get records free once a year

Other Comments:

Authorization To Release Protected Information

*** Required** – Please check the boxes below, indicating how protected information should be handled even if categories do not necessarily apply to the patient's medical records.

Patient/Parent/Guardian's Initials:

☐ I DO ☐ I DO NOT want information about ***Mental Health** released _____

☐ I DO ☐ I DO NOT want information about ***Psychiatric Treatment Notes** released _____

☐ I DO ☐ I DO NOT want information about ***HIV Tests & Related Information** released _____

☐ I DO ☐ I DO NOT want information about ***Alcohol and/or Substance Abuse** released _____

☐ I DO ☐ I DO NOT want information about (other) _____ released _____

STOP Please confirm that you have put a **checkmark and initialed all** the protected information categories above regardless if they are applicable or not. If this form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Sensitive Information

Please check below any category of sensitive information that you **DO NOT** want released.

☐ Abortion ☐ Sexually Transmitted Disease ☐ AIDS/ARD ☐ Genetic ☐ Domestic Sexual Assault

☐ Other(s): _____

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Patient's Name (Print): _____ Date: _____

Patient's Signature: _____ Date: _____
(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance abused records)

Parent or Legal Guardian (Print): _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

MHC Healthcare Staff (Name): _____ Date: _____

MHC Healthcare Staff Signature: _____ Date: _____

- This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the health center took before it received the revocation.
- I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.
- I understand that my treatment or continued treatment by MHC Healthcare and its affiliates is in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.
- I understand that I may inspect a copy of the information that is used or disclosed.

FOR INTERNAL USE ONLY

☐ EMR Only ☐ Paper Chart (scanning completed) ☐ Verify Picture ID

Location: Employee: Date: