

**REQUEST FOR MEDICAL RECORDS**

Acuity Specialty Hospital of Ohio Valley at Belmont

**Patient Request** for Release of Information

**I AM A PATIENT OF ACUITY HEALTHCARE OR THEIR REPRESENTATIVE AND THE PATIENT INFORMATION IS LISTED BELOW (PLEASE PRINT):**

First Name:	MI:	Last Name:
Date of Birth:	Phone:	Last 4 digits SSN:
Address:	City:	State & Zip:

**WHICH RECORDS WOULD YOU LIKE TO RECEIVE? (ENTER THE ADMISSION AND DISCHARGE DATE, THEN SELECT THE APPROPRIATE BOX(ES)):**

Admission Date:	Discharge Date:
<input type="checkbox"/> Discharge Summary <input type="checkbox"/> History & Physical <input type="checkbox"/> Consultations <input type="checkbox"/> Progress Notes <input type="checkbox"/> Operative Reports	<input type="checkbox"/> Diagnostic Test Results <input type="checkbox"/> Laboratory Results <input type="checkbox"/> X-ray/CT/MRI Reports <input type="checkbox"/> Pathology Reports <input type="checkbox"/> EKG's / ECG's
<input type="checkbox"/> Drug/Alcohol Records <input type="checkbox"/> HIV Records <input type="checkbox"/> Mental Health Records <input type="checkbox"/> Medications <input type="checkbox"/> Other (Please Specify): _____	<input type="checkbox"/> Face Sheet <input type="checkbox"/> Abstract <input type="checkbox"/> Itemized Bill

**HOW WOULD YOU LIKE TO RECEIVE THE REQUESTED MEDICAL RECORDS?**

Select one: <input type="checkbox"/> CD <input type="checkbox"/> Fax <input type="checkbox"/> E-mail <input type="checkbox"/> Paper Copies → <input type="checkbox"/> Mail <input type="checkbox"/> On-site Pick Up <input type="checkbox"/> Review Medical Record on-site/in person NOTE: E-mail and CD will be encrypted or password protected unless otherwise requested here → <input type="checkbox"/> No encryption or password required
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**WHEN WOULD YOU LIKE TO RECEIVE THE REQUESTED MEDICAL RECORDS?** \_\_\_\_\_

NOTE: We will make every effort to send your records as soon as possible but this process may take up to 30 days.

**PLEASE INDICATE WHERE YOU WOULD LIKE THE RECORDS TO BE SENT (PLEASE COMPLETE APPLICABLE SECTION(S) BELOW):**
**Acuity Healthcare should provide my records to:**  Self     Personal Representative (indicated below)

Recipient Name:	Recipient Phone:
Recipient Mailing Address:	Recipient Fax:
	Recipient E-mail:

**THIS AUTHORIZATION WILL EXPIRE IN 6 (SIX) MONTHS OR (SPECIFY DATE OR EVENT):** \_\_\_\_\_

Printed Name of Patient or Personal Representative:	Relationship (please print):
Signature of Patient or Personal Representative:	Date: _____ Time: _____

**PLEASE RETURN COMPLETED AND SIGNED FORM TO:**

Health Information Management Director - ROI Acuity Specialty Hospital of Ohio Valley at Belmont 4697 Harrison Street – 2 <sup>nd</sup> Floor Bellaire, OH 43906	Fax: 740-671-2095 Phone: 740-671-2089
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- Acuity Healthcare recognizes a patient's right under HIPAA to access copies of his/her health information.
- There may be a fee associated with producing requested records. Please see the fee schedule for this Acuity Healthcare facility.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

**For Office Use Only**

Date of release: \_\_\_\_\_ via mail fax CD other \_\_\_\_\_ ID verified DL/Other ID \_\_\_\_\_

Employee Name &amp; Title: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**\*\*\* ATTENTION \*\*\***

This message may contain confidential and/or privileged information. If you are not the addressee or authorized to receive this for the addressee, you must not use, copy, disclose, or take any action based on this message or any information herein. If you have received this message in error, please advise the sender by fax immediately and destroy this form. Thank you for your cooperation.