Community Health Network

PATIENT IDENTIFICATION

PATIENT MEDICAL RECORDS ACCESS REQUEST

Not to be used for VERBAL communication

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH:_____ Last 4 digits of SS#: _____

Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____

Clinic/Hospital/ Healthcare Provider-

(**Who** has the information you want released? Please list the specific Hospital and/ or clinic)

Location (check all that apply):

☐ Community Hospital East (CHE)	☐ Community Hospital North	☐ Community Hospital South
☐ Community Heart and Vascular (a facility under CHE)	☐ Community Westview (a facility under CHE)	☐ Community Howard Regional Health
☐ Community Howard Specialty Hospital	☐ Medcheck	☐ Imaging Centers
☐ Community Howard Behavioral Health	☐ Community Home Health	☐ Community Digestive Center Anderson
☐ Community Behavioral Health Outpatient	☐ Community Surgery Center East	☐ Community Surgery Center Hamilton
☐ Community Endoscopy Center Indianapolis	☐ Community Surgery Center North	☐ Community Surgery Center Northwest
☐ Community Surgery Center Howard	☐ Community Surgery Center South	☐ Community Surgery Center Plus
☐ Physical Therapy Offices	☐ Oncology Centers	
☐ Community Physician Network		

Physician_____ Practice Name_____

Receiving Party

(**Where** and to whom do you want the records sent?)

☐ Me ☐ Other

NAME: _____

Address: _____ City: _____ State: _____ Zip: _____

Day Phone: _____ Fax Number _____

Email Address: _____

Information to be Released

(**What** do you want? Check the appropriate box(es).)

Disclosure will include (check all that apply):

☐ Consultation Report	☐ Discharge Summary/Notes	☐ Emergency Record(s)	☐ History and Physical Report	☐ Forensic Photos	☐ Entire Record
☐ Immunization/Allergy Records	☐ Laboratory/Pathology Report	☐ Medication Report	☐ Office Visits	☐ Operative Report	☐ Communicable Diseases
☐ Progress Notes/Clinic Notes	☐ Films/Images	☐ Therapy Records	☐ X-ray/Radiology Report	☐ Forensic Consult	☐ Billing Records
☐ Substance Abuse Records	☐ Mental Health Records	☐ BH Treatment Plan	☐ BH Diagnosis	☐ BH Evaluation/Assessment	

☐ Other records specify record type(s) _____

OPTIONAL Limits – Disclose only records related to following:

Date(s) of service: _____Injury or illness: _____

Release Instructions

(**How** and **When** do you want the information?)

Date information is needed:_____ (NOTE: PLEASE ALLOW 30 DAYS FOR PROCESSING)

Release Method/Format requested: (check one)

☐ MyChart ☐ Paper ☐ CD/DVD ☐ Fax __

☐ Secured e-mail _____

☐ Unsecured e-mail _____ ***(E-mail is not a secure form of communication. See page 2 for details)***

☐ I have read the warning on page 2 and wish to receive my records from Community Health Network via unsecured e-mail.

_____

Signature for Unsecured Email

☐ Other* _____

*Requests for other methods of delivery will be reviewed on a case by case basis

_____ _____ _____

Patient/Legal Guardian Signature Date/Time Authority to act on behalf of patient (attach document)

_____ _____

Witnessed by Released by

Community Health Network

DIRECTIONS FOR COMPLETION OF THIS FORM

Patient Information: Complete the entire section which identifies clearly and legibly all of the demographic information specific to the patient (individual who information is being requested for).

Clinic/Healthcare Provider: Identify which Community Health Network facility you are seeking information from (or to be sent to). **Please be specific** in your request. For example, when choosing Community Physician Network please add either the name of the provider or the practice name you are requesting. If you do not identify a specific facility, records may be provided to **ALL** Community Health Network facilities where you have received care. Please see www.eCommunity.com for a listing of Community Health Network locations and names.

Receiving Party: Identify the full name/business, address, phone and contact information with the name of the individual who is to receive the information. *Please allow 30 days for all requests to be processed and sent to the recipient.*

Information Requested: This section gives us the instructions for what information you want released.

Release Instructions: This tells us how you would like your information delivered. We can print the documents, mail, secure email, or create a CD. If we are unable to provide in the format desired we will contact you to make other arrangements.

Please read the warnings below and sign on the front of the page if you agree to unsecure e-mail.

- Any e-mail (including those claiming to be private) is often compared to a postcard in that anyone who comes in contact with it can read it.
- E-mail may be read when it is stored on internet service provider servers.
- E-mail is hard to destroy because it is archived/stored on e-mail servers.
- Medical records contain extensive data with monetary value and can be bought and sold on "the dark web" for medical identity theft and other illicit purposes.

Contact Information

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