PATIENT ACCESS FORM

Section A: This section must be completed	l for all requ	iests for	r access					
Patient Last Name		F	First Name MI					
Date of Birth		5	Social Security Number (optional):					
Address:								
City:			State:			Zip:		
Phone Number:			Email Address:					
Name at time of treatment, if different	than above	e:						
Name and address of health provider or entity who will provide you with access to this information:								
Where do you want the information sent? Self or Personal Representative (indicated below)								
Personal Representative Name:								
Address:								
City:		S	State: Z					
Phone Number:		E	Email Address:					
Fax Number:								
What records are you requesting?		ı		I	ı			
What records are you requesting? Description:	Date(s):	Descri	iption:	Date(s):	Description);	Date(s):	
Description: ☐ All Protected Health Information in	Date(s):		-	Date(s):	Other:	<i>ı:</i>	Date(s):	
Description: ☐ All Protected Health Information in medical record	Date(s):	☐ Di	scharge Summary	Date(s):	Other:);	Date(s):	
Description: ☐ All Protected Health Information in	Date(s):	☐ Di	-	Date(s):	Other:	<i>):</i>	Date(s):	
Description: ☐ All Protected Health Information in medical record ☐ Admission form ☐ Physician orders	Date(s):	Di Pr	scharge Summary rogress Notes itial Evaluation emized bill	Date(s):	Other:	<i>1:</i>	Date(s):	
Description: ☐ All Protected Health Information in medical record ☐ Admission form	Date(s):	Di Pr Ini	scharge Summary rogress Notes itial Evaluation emized bill story and Physical exam	Date(s):	Other:	<i>:</i> :	Date(s):	
Description: All Protected Health Information in medical record Admission form Physician orders Medication Sheets Lab Tests		Di Pr Ini Ite	scharge Summary rogress Notes itial Evaluation emized bill story and Physical exam adiology Reports	Date(s):	Other:	i:	Date(s):	
Description: ☐ All Protected Health Information in medical record ☐ Admission form ☐ Physician orders ☐ Medication Sheets		Di Pr Ini Ite	scharge Summary rogress Notes itial Evaluation emized bill story and Physical exam adiology Reports	Date(s):	Other:	<i>):</i>	Date(s):	
Description: ☐ All Protected Health Information in medical record ☐ Admission form ☐ Physician orders ☐ Medication Sheets ☐ Lab Tests Please describe the exact nature and dates of Preferred method of delivery: ☐ secure emails.	medical reco	Di Pr Ini Ite	scharge Summary rogress Notes itial Evaluation emized bill story and Physical exam adiology Reports		Other: Other: Other:		Date(s):	
Description: ☐ All Protected Health Information in medical record ☐ Admission form ☐ Physician orders ☐ Medication Sheets ☐ Lab Tests Please describe the exact nature and dates of ☐ Preferred method of delivery: ☐ secure email Other electronic method (USB, CD, other	medical reco	Di Pr Ini Ite	scharge Summary rogress Notes itial Evaluation emized bill story and Physical exam adiology Reports t you would like.		Other: Other: Other:		Date(s):	
Description: ☐ All Protected Health Information in medical record ☐ Admission form ☐ Physician orders ☐ Medication Sheets ☐ Lab Tests Please describe the exact nature and dates of Preferred method of delivery: ☐ secure emails.	medical reco	Di Pr Ini Ite	scharge Summary rogress Notes itial Evaluation emized bill story and Physical exam adiology Reports t you would like.		Other: Other: Other:		Date(s):	
Description: ☐ All Protected Health Information in medical record ☐ Admission form ☐ Physician orders ☐ Medication Sheets ☐ Lab Tests Please describe the exact nature and dates of ☐ Preferred method of delivery: ☐ secure email Other electronic method (USB, CD, other	medical reco	Di Pr Ini Ite	scharge Summary rogress Notes itial Evaluation emized bill story and Physical exam adiology Reports t you would like.		Other: Other: Other:		Date(s):	
Description: ☐ All Protected Health Information in medical record ☐ Admission form ☐ Physician orders ☐ Medication Sheets ☐ Lab Tests Please describe the exact nature and dates of ☐ Preferred method of delivery: ☐ secure email Other electronic method (USB, CD, other	medical reco ail ☐ mai r). Please sp n below:	Di Pr Ini Ra	scharge Summary rogress Notes itial Evaluation emized bill story and Physical exam adiology Reports t you would like.		Other: Other: Other:		Date(s):	
Description: ☐ All Protected Health Information in medical record ☐ Admission form ☐ Physician orders ☐ Medication Sheets ☐ Lab Tests Please describe the exact nature and dates of ☐ Other electronic method (USB, CD, other please print your name and sign	medical reco ail ☐ mai r). Please sp n below:	Di Pr Ini Ra	scharge Summary rogress Notes itial Evaluation emized bill story and Physical exam adiology Reports t you would like.	☐ fax ☐	Other: Other: Other:		Date(s):	
Description: ☐ All Protected Health Information in medical record ☐ Admission form ☐ Physician orders ☐ Medication Sheets ☐ Lab Tests Please describe the exact nature and dates of ☐ Other electronic method (USB, CD, other please print your name and sign	medical reco ail ☐ mai r). Please sp n below:	Di Pr Ini Ra	scharge Summary rogress Notes itial Evaluation emized bill story and Physical exam adiology Reports t you would like.	☐ fax ☐	Other: Other: Other:		Date(s):	
Description: ☐ All Protected Health Information in medical record ☐ Admission form ☐ Physician orders ☐ Medication Sheets ☐ Lab Tests Please describe the exact nature and dates of ☐ Other electronic method (USB, CD, other please print your name and sign	ail □ mair). Please spon below:	Di Pr Ini Ra	scharge Summary rogress Notes itial Evaluation emized bill story and Physical exam adiology Reports t you would like. pick up of paper copies	☐ fax ☐	Other: Other: Other:		Date(s):	

Select Medical recognizes a patient's rights under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.