CHESAPEAKE REGIONAL HEALTHCARE

1ADMIN

PATIENT REQUEST FOR HEALTH INFORMATION

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	Email (optional):	
Street Address:	City:	State:	Zip Code:

What records do you want? (Check appropriate boxes below):

Date(s) of Service: ____ / ____ / ____ through ____ / ____ / ____

☐ Discharge Summary ☐ Emergency Room Records ☐ Operative/Procedure Reports ☐ Billing Records

☐ Test Results (X-Rays, Lab/Pathology Results) Please specify: _____

☐ Other (Immunization Records, Medication Lists) Please specify: _____

How would you like your records delivered?

☐ Paper

☐ Home Delivery

☐ In-Person Pickup

☐ Electronic (USB, CD, Portal, Other) Please specify: _____

Where do you want the information sent? (Fill in boxes below):

Chesapeake Regional Healthcare should provide my records to: ☐ Self ☐ Personal Representative (indicated below)

Recipient Name:	Recipient Phone:	Recipient Fax:
Recipient Mailing Address:	Recipient Email (if applicable):	

Please print your name and sign below:

Name of Patient of Personal Representative (please print):	Relationship (please print):
Signature of Patient of Personal Representative:	Date/Time:

Please return completed form to:

	Email: Fax:
	Questions?

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