SHENANDOAH PAIN AND PALLIATIVE CARE CLINIC
Patient Request for Access to Patient Medical Records

Under the Health Insurance Portability and Accountability Act, patients or their designated representatives may request copies of a patient's medical records, or summaries or explanations of those records. To submit your request, please complete the below form.

If you request a copy of your medical records or agree to a summary or explanation of such information, SHENANDOAH PAIN AND PALLIATIVE CARE CLINIC may impose a reasonable, cost-based fee for providing the records, summaries, or explanation, provided that the fee includes only the cost of:

- Labor for copying the health information requested by you, whether in paper or electronic form.
- Supplies for creating the paper copy or electronic media if you request that the electronic copy be provided on portable media;
- Postage, when you have requested the copy, or the summary or explanation, be mailed; and
- Preparing an explanation or summary of the health information, if you have agreed in advance to have a summary or explanation provided, and you have agreed in advance to the fees for such summary or explanation.

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:	E-mail (optional):	
Street Address:	City:	State:	Zip:

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 (Email, USB, CD, Portal, Other) Please specify: _____

Where do you want the information sent? (Circle the desired option):

Self Personal Representative

Contact Information for Personal Representative:

Representative Name:	Representative Phone: Representative Fax:
Representative Mailing Address:	Representative E-mail (if applicable):

Please print your name and sign below:

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

Please return completed form to:

[Name, Address, and Telephone Number of Organization]	**(optional)** **E-mail:** **Fax**:
	Questions?