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, CD, Portal, Other) Please specify: _____

Note: The Columbus Access Patient Portal contains only laboratory and radiology results. A valid email address provides you access to your own information.

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

Columbus Community Hospital will provide my records to: ☐ Self ☐ Personal Representative (indicated below)

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient 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:

Columbus Community Hospital Health Information Department	**E-mail:** release@columbusch.com **Fax**: 979-732-9242
	Questions? 979-493-7554

Columbus Community Hospital 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.

If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, psychiatric diagnosis or sexually transmitted disease, you are hereby authorizing disclosure of this information.

This authorization expires 180 days from the date signed below and covers only treatment dates specified above.