

## PATIENT DIRECTED REQUEST FOR PROTECTED HEALTH INFORMATION

Patient Information	Name of Patient:		Patient's Date of Birth:/
mormation	Address:		710
	City: State: ZIP:		
Ph#: Previous Name(s):			
	Medical Group*/Beacon Health, LLC/Med Point		•
□ Bremen □ Elkhart General Hospital □ Memorial Hospital/Epworth			
*Beacon Medical Group Location/Doctor's Name:			
Address:			
City:	State	e:	ZIP:
Dates to be released: / / to / /			
☐ Clinic Records — Beacon Medical Group site — (2 year summary unless otherwise specified)			
(General Abstract: Office Clinic Notes, Consults, Labs, Test Results)  Hospital Records			
(General Abstract: Discharge Summary, History & Physical, Consults, Operative Reports, Labs, Radiology Reports, and ER records)			
Medication Lists  Billing Records  Face Sheet  Labs  Radiology  Discharge Summary			
□ ER - Emergency Room Records □ Operative/Procedure Reports □ Immunization Records □ Consult			
Copies of Films/Images (list details of type, where taken, etc.):			
Other (list details):			
** Behavioral health/Mental illness records			
** Treatment of Communicable Disease, including HIV/AIDS, hepatitis and venereal diseases, etc.			
** Substance abuse treatment (i.e., alcohol and/or drug)			
Delivery Method			
Secure Electronic Delivery: Un-encrypted email is not a secure means of communication. We <u>will encrypt</u> email communications of your records <u>unless</u> you tell us that you prefer us to use un-encrypted email. If you prefer we <u>not encrypt</u> our communications to you, please initial here:			
List valid email address for Electronic Delivery (please print):			
☐ Mail			
In-Person Pic	•	eview Only	
CD/DVD (not available with all records)  Other:			
Provide Records To			
Name:		Ph#:	Fx#:
Address:			
City:		State:	ZIP:
Beacon Health System 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 records.			
Signature of Patient of	or Personal Representative:		Date/Time:
Printed name of Patie	nt or Personal Representative:	Relationship to Patient (Pe	rsonal Representative - provide documentation )