GRAND LAKE™ HEALTH SYSTEM

200 St. Clair Street
St. Marys, Ohio 45885
(419) 394-3335

# PATIENT REQUEST FOR ACCESS TO HEALTH INFORMATION

GLHS recognizes a patient's right of access under HIPAA.

Patient Name: ______________________________ Patient Date of Birth: ____________________

1. Request access for Dates of Service:____________________
   OR ☐ Any and All Past, Present and Future information (until revoked in writing)

2. Information to be accessed or released: (check all that apply)
   Hospital
   - ☐ Discharge Summary
   - ☐ History & Physical
   - ☐ Consultation
   - ☐ Operative Report
   - ☐ Discharge Instruction Sheet
   - ☐ ER Chart
   - ☐ Urgent Care Chart
   - ☐ Laboratory Reports
   - ☐ Medical Imaging Reports/CD Images
   - ☐ EKG
   - ☐ Physician Orders
   - ☐ Progress Notes
   - ☐ All Dictated Reports
   - ☐ Other (specify):________________ ____________________________

   Grand Lake Physician Practices
   - ☐ GLPP Office Notes; Office Name: ______________________________
   - ☐ All GLPP Office Notes (All Offices)

   OR ☐ Any and All medical information (until revoked in writing)

3. Requestor: (check one) ☐ Self (Patient) ☐ Patient Representative; Name ____________________
   IF Patient Representative, check one below AND validate parent OR documents
   ☐Parent/Guardian ☐HPOA ☐Executor of Estate ☐Other: __________

4. How would you like record copies delivered? (check all that apply)
   ☐ Paper Copy ☐ Electronic Copy via USB/Flash Drive (ONLY on device supplied by GLHS)
   - ☐ In-Person Pickup (self)
   - ☐ Allow someone else to pick up my records; Name: ______________________________
   - ☐ Mail Delivery; Street Address: ______________________________
     City/State/Zip: ______________________________

   ☐ Email Copy; email address: ______________________ * NOTE: EMAIL is NOT a secure method of sending medical information. I understand I am requesting my information to be sent in a non-secure method. ________ (patient initials)

   ☐ Fax copies to Patient (Note: Confirm with patient that their fax machine is in a secure location) (GLHS is not responsible for unauthorized disclosure as a result of an unsecured patient fax machine). Patient Initials _______

   ☐ Release Lab Results over the phone. Please provide a password ______________________________ (GLHS is not responsible for unauthorized disclosure as a result of someone other than the patient calling to receive Lab Results over the phone with above identified password). Patient Initials _______________

______________________________ ______________________
Signature of Patient or Representative Date

---

*For Internal use only:*

| *Patient MRN #:* | *Patient Visit #:* | |
|---|---|---|
| *Date Requested:* | *Date Completed:* | *Completed By:* |