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. Information to be accessed or released: (*check ONLY ONE box* below)

☐ **ALL Grand Lake Health System Records**: This includes BOTH Joint Township District Memorial Hospital (JTDMH) AND Grand Lake Physician Practice (GLPP) records

OR

☐ **ONLY Hospital Records (Joint Township District Memorial Hospital)**

- ☐ All portions of the hospital record
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation
- ☐ Operative Report
- ☐ Discharge Instruction Sheet
- ☐ ER Chart
- ☐ Urgent Care Chart
- ☐ Laboratory Reports
- ☐ Medical Imaging Reports/CD Images
- ☐ EKG
- ☐ Rehab/Therapy
- ☐ Physician Orders
- ☐ Progress Notes
- ☐ Physician Reports
- ☐ Pain Clinic
- ☐ Other (specify): _____ _____

OR

☐ **ONLY Grand Lake Physician Practice Records**

- ☐ All Physician Practices
- ☐ Specific Office/Provider: _____

## 2. Dates of Service to Release:

☐ Any and All Past, Present and Future information (until revoked in writing)

OR

☐ ONLY release specific Dates of Service: _____

## 3. Requestor: *(check one)* ☐ Self (Patient)

OR

☐ Patient Representative; Name _____

If Patient Representative, check one below AND validate parent or HPOA 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: _____

☐ Fax copies to Patient (GLHS is not responsible for unauthorized disclosure as a result of an unsecured patient fax machine).

☐ Release Lab Results over the phone. Please provide a password _____

NOTE: (GLHS is not responsible for unauthorized disclosure if someone other than the patient calls to receive results over the phone with above identified password). Patient Initials _____

_____ _____

**Signature of Patient or Patient Representative** **Date**

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*For Internal use only:*

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