REQUEST BY PATIENT OR PATIENT REPRESENTATIVE FOR ACCESS TO PROTECTED HEALTH INFORMATION FORM

1. Patient Name (Please Print): _____
   Patient Address: _____
   Date of Birth: _____ Last 4 Digits of SS #_____Telephone #: _____
   ❑ **Provide a copy of my health information to me.**
   ❑ **Send my health information to the person/organization or personal representative listed below:**
   Name:_____ Telephone: _____
   Address/City/State/Zip:_____

2. Location(s) where the service was provided – check below:

Franciscan Health Hospital:		**Other Franciscan Services:**
❑ Hammond	❑ Lafayette Central	❑ Independent Diagnostic Testing Facility Carmel
❑ Dyer	❑ Lafayette East	❑ Retail Pharmacy; Location_____
❑ Munster	❑ Crawfordsville	❑ Home Health; Location_____
❑ Michigan City	❑ Rensselaer	❑ Hospice; Location_____
❑ Crown Point	❑ Indianapolis	❑ Durable Medical Equipment
❑ Chicago Heights	❑ Mooresville	❑ Franciscan ExpressCare; Location_____
❑ Olympia Fields	❑ Carmel	❑ Franciscan Working Well; Location_____
❑ Beech Grove	❑ Orthopedic Hosp Carmel	❑ Franciscan Health eAccess; Location_____
		❑ Franciscan Sports Medicine (Healthy Roster for student athletic programs)

   ❑ Physician/Specialist Office Location: _____
   Provider Name: _____
   ❑ Other _____

3. Include the following date(s) of service:_____

4. Send the following record type(s) – check below:
   ❑ Lab Results ❑ Radiology Results ❑ Cardiology Results ❑ ER Record ❑ Operative Report
   ❑ Progress Notes ❑ Discharge Summary ❑ Immunization Report ❑ History & Physical ❑ Consultation
   ❑ Discharge Instructions/After Visit Summary ❑ Fetal Monitor Strips ❑ Radiology Images
   ❑ Forensic Sexual Assault Record ❑ Billing Records
   ❑ Medical Record ❑ Other (specify): _____
   Select to indicate whether Substance Use Disorder Records should be included: ❑ Yes ❑ No

5. Send the health information in the following format: ❑ Paper ❑ Electronic (PDF) ❑ Other _____

6. Delivery Method (note that paper, CD/DVD and USB are delivered by US Mail):
   ❑ CD/DVD ❑ USB ❑ MyChart ❑ Fax Number: _____
   ❑ Other: _____
   ❑ Email Address: _____ (sent via secure email unless you initial below)
   _____ I understand that unencrypted e-mail or media (CD/DVD/USB) is not a secure delivery method but I choose to have my records sent without encryption. I will not hold Franciscan Health, any affiliated organization, physician, or supplier liable for any unintended breach of confidentiality due to my choice of unsecure delivery.

7. Fees: State and federal law allow Franciscan to charge a fee for any request for records that will require manual effort to compile and transmit. Please contact us if you have questions or would like an estimate of fees in advance. Note that you can electronically access your records for free through your MyChart account.

   SIGNATURE:_____ DATE:_____

   RELATIONSHIP TO PATIENT, if other than patient: _____

   NOTE: Unless a parent of a minor patient, personal representatives must attach proof of authority to this request.

Franciscan HEALTH

Place Patient Label

Form: Rev: 12-01-23
Barcode Revision: 01-23-26

HIPAA RELEASE OF INFORMATION ACUTE

HIPAA Release of Information Acute