St. Vincent Hospital
Here for you, your family, your community.

Patient Label

Patient Request to Access Medical Records Form *SVH has 10 business days to complete this request

Name of Facility / Entity: **St Vincent General Hospital District / St. Vincent Medical Clinic**

Patient's Full Name:					
E-mail Address:					
Street Address:					
City:		State:		Zip Code:	
Phone#:		Date of Birth:			
Last 4 of Social Security #:		Driver's License/State-Issued ID#			

I'm requesting access to (please check one}: ☐ View Records ONLY ☐ Obtain Copies of Records

Please complete the following information:

Date(s} of service associated with request (e.g. date of treatment, date of office visit): Date Ranges: _____ - _____

If Requesting copies, please describe the reason for the request:

☐ Further Medical Care ☐ Worker's Comp ☐ Personal Use
☐ Insurance ☐ Legal
☐ Other: _____

Describe the information you are requesting to view or obtain copies of:

☐ D/C Summary ☐ Labs ☐ Radiology
☐ Op Report ☐ H&P/Consult ☐ ER Record ☐ Medications
☐ Physician Orders ☐ Progress Notes ☐ Specific Studies ☐ Psych Health
☐ Complete Medical Record ☐ Other: _____

I certify that this request to access health information is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that St. Vincent General Hospital (SVGHD) may not be able to grant me access to certain types of health information and information belonging to minors between the ages of 13-17 will not be accessible to ensure compliance with legal requirements regarding access to patient records. I understand that if I need to obtain hard copies there may be a charge associated with such copies.

Signature of Patient / Legal Representative: _____ Date/Time: _____/_____

If Legal Representative, Print Name: _____ Relationship to Patient:_____

SVGHD Use Only Request Received By: _____ Date Received: _____
Medical Record #: _____ Identity Verification (DL# / Other ID#): _____
☐ Request Approved (Date: _____/_____/_____) ☐ Request Denied (Date: _____/_____/_____)
Date Completed: _____/_____/_____ Completed By: _____
Reason for Denial: _____

PSYCHIATRIC RECORD PHYSICIAN APPROVAL: I am the attending physician for the above named patient. I have reviewed the medical record(s) to determine if they contain information relative to psychological or psychiatric problems which, if revealed to the patient is reasonably likely to endanger the life or physical safety of the individual or another person.
These portions of medical record(s): ☐ May be released to the patient ☐ May NOT be released to the patient
Signature of Physician or Designee: _____ Date: _____ Time: _____
Print Name of Physician: _____