

Patient Request to Access Medical Records Form

Name of Facility / Entity: **St Vincent General Hospital District / St. Vincent Leadville 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
	Physician Orders	Progress Notes	Specific Studies
	Complete Medical Record	Other: _____	
			Medications
			Psych Health

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: _____