CommonSpirit

CHI St. Francis Health

2400 St Francis Drive
Breckenridge, MN 56520

Patient Access Request to Their Protected Health Information

This form is for patient requests to access (view), receive or send copies of **their own medical information.**

To verify your identity and provide the correct information, please complete the below:

Patient Name _____Date of Birth _____
Patient Previous/Other Name(s):_____
Email Address:_____
Address _____Phone number_____
City _____ State_____ Zip_____

Facilities or locations from which you are requesting records. Please list or check as appropriate:

CHI St. Francis Health **CHI St. Francis Clinic**

Dates of Service (please list date or date range for records requested)
From _____ To _____

Parts of the record requested:
(Below are the most frequently requested documents. This does not constitute your entire medical record, which you have the right to request.*)

Check (✓) all that apply:

__ Abstract (Includes[1])
__ Discharge Summary /Final Diagnosis[1]
__ History and Physical Records[1]
__ Consultation Reports[1]
__ Operations and Procedures[1]
__ Results of Diagnostic Testing[1]
__ Emergency Room Records
__ Lab Reports
__ Radiology (for example: X-Ray) Reports
__ Other Diagnostic Reports
__ Diagnostic Images (Prepped by Radiology Dept)
__ Immunization (shot) Record
__ Physical Therapy Notes
__ Physician Notes
__ Medication List
__ Itemized Bill

__ Other*: _____

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I request the form of release of information be:
____ Electronic (HIM Department Portal) *email address required: _____

_____ Paper (U.S. Mail or pick up) ____ Other (USB, etc...**)_____

**Device must be provided by the facility

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

I will pick up the records (check here) _____
(or)
Please send the records to the person or party(ies) below at the address provided:

Recipient Name:_____

Address for receipt of record:
_____
_____
_____
_____

Email Address for receipt of records:
_____

I understand there may be a minimal fee charged for the records.

Signature of Patient or Guardian

_____ Date_____

Print name _____

If you are the Personal Representative of the Patient:
Signature of Personal Representative_____

Authority or relationship to patient _____

(Please include copies of any documents that establish Personal Representation such as Power of Attorney document, Guardianship papers, Executor of Estate or Administrator of will documents.)