AdvocateAuroraHealth®

PATIENT REQUEST FOR HEALTH INFORMATION

MRN: _____

For Office Use Only

Today's Date: _____

Patient Information:

_____

First Name MI Last Name

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Phone Number: _____ Previous Name: _____

I request Advocate Aurora Health to provide my health information to:

☐ Myself or ☐ _____

Name of Health Care Provider / Insurance / Attorney / Other

Delivery Method Requested:

☐ Advocate Aurora Health (AAH) Patient Portal

☐ Mail To: _____

Address City State Zip

☐ Email address: _____

Fees: (we will contact you to inform you of the fee that will be assessed)

- via AAH Patient Portal: No Fee
- via Email or Compact Disc sent directly to patient: Nominal Fee
- via US Mail to patient for paper copies: Per page fee and postage
- If to a third party in any format: regulatory rates will apply

Format Requested:

☐ In-Person Pickup ☐ Encrypted CD ☐ Paper ☐ Other _____

☐ Encrypted email ☐ Non-Encrypted email ☐ Non-Encrypted CD

(I was informed and understand the risks of receiving records via unsecured email or CD and that personal health information could be accessed by a third party while in transit. I still want the records in this manner.)

The records that I want include *(check boxes below or specify)* **Dates of Service:** _____

☐ Billing Records related to (specify): _____

☐ Emergency Department Reports

☐ Hospital Summary – a general abstract will be sent which includes Discharge Summary, H&P, Consults, Operative Reports, Labs, Radiology Reports & ER.

☐ Imaging Films (X-ray)

☐ Imaging Results

☐ Immunizations

☐ Lab Reports

☐ Procedure Op Reports

☐ Progress Notes/Updates

☐ Other: _____

Patient/Personal Rep Signature: _____

Print Name and Signature

Advocate Aurora Health will accept any written request from a patient for access to or copies of their own medical record. This form is not required. However, it provides all the needed information to correctly process your request.

For Office Use Only:

Health Information Management (HIM) Department Verification (Staff *initial* box when verification has been confirmed):

☐ Demographic information (Name, DOB, Address, Phone Number, email address, last 4 digits of SS#)

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(HIM ROI Patient Request)