CRAIG

3425 S. Clarkson St.
Englewood, CO 80113
303-789-8232

Patient Request to Access Medical Records Form

Patient's Full Name:					
Email 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/copies of the following:

- ☐ Medical Records
- ☐ Radiology Images on CD
- ☐ Billing Records
- ☐ View Records Only

I would like to receive my records as follows:

- ☐ Mail to Above Address
- ☐ Send Via Encrypted Email
- ☐ Send Via Unencrypted/Unsecure Email
- ☐ Fax to: _____
- ☐ Personal Pick-Up
- ☐ Encrypted USB
- ☐ Encrypted CD
- ☐ Paper

☐ Send to third party: (select a method)

Name: _____
Address: _____
_____
Phone: Fax: _____
Email:

Date(s) of service/treatment associated with request:

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

- ☐ Entire Record
- ☐ Labs
- ☐ Urology
- ☐ Psychology
- ☐ Other:
- ☐ Discharge Summary
- ☐ Radiology Reports
- ☐ Team Conferences
- ☐ PT / OT / ST Initial/Discharge Evaluations (circle)
- ☐ H&P
- ☐ Consults
- ☐ Outpatient Records

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.

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

Print Name/Relationship: _____ Date: _____

*Note: If legal representative, provide a copy of the documentation that establishes you as the legal representative.

Craig Hospital Use Only: Individual Who Received Request: _____ Date Request Received: _____

Verification of Identity:

ROI #: _____ Medical Record #: _____

Date Fulfilled (copies delivered/inspection complete): _____ Individual Who Fulfilled: _____

☐ USB ☐ CD ☐ Faxed ☐ Mailed ☐ Emailed # of Pages: _____ ☐ Radiology CD Qty: _____

Patient Acknowledgement of Inspection (viewing only): Date: