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

Patient Request to Access Medical Records Form

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

1. I'm requesting access to/copies of the following:	2. I would like to receive my records as follows:	3. Choose one for medical records:
☐ Medical Records ☐ Radiology Images on CD ☐ Other:	☐ Mail to Above Address ☐ *Send Via Encrypted Email ☐ *Send Via Unencrypted/Unsecure Email ☐ Personal Pick Up ☐ Fax to: _____ *Size limitations apply. If too large to email, a USB will be mailed.	☐ Encrypted USB ☐ Encrypted CD ☐ Paper

☐	Send to Doctor, Hospital or Other:	Name: _____ Address: _____ _____ Phone: _____ Fax: _____ Email:

Date(s) of Service/Treatment Associated with Request:	
Select the information you are requesting to view or obtain copies of:	☐ Entire Record ☐ History & Physical ☐ Discharge Summary ☐ Labs ☐ Radiology Reports ☐ Consults ☐ Urology ☐ Team Conferences ☐ Outpatient Records ☐ Psychology ☐ PT / OT / ST Initial & Discharge Evaluations ☐ 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.

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 ☐ For Pick-up # of Pages _____ ☐ Radiology CD Qty: _____

Patient Acknowledgement of Inspection (viewing only): Date: