PATIENT ACCESS REQUEST FORM

*******Please Note: Reasonable charges MAY apply*******

Patient Name: _____

Address: _____

Address: _____

Date of Birth: _____

Patient Phone Number: _____

Medical Record #: (if known) _____

I am requesting a copy of my medical information from Geisinger* pursuant to the HIPAA Right of Access provisions.
I am requesting records from the following entities:
☐ All Sites ☐ Specific Clinic or Hospital_____ .

Please produce records form the following dates: _____ to _____ ("present" equals date of signature).

SPECIFIC INFORMATION TO RELEASE - (Check box of items to be released)

☐ Clinic Notes
☐ Colonoscopy
☐ Consultation Report(s)
☐ Disability/FMLA Form
☐ Discharge Summary
☐ EEG, EKG, Stress Test
☐ Emergency Department Notes
☐ Endoscopy
☐ History and Physical
☐ Immunizations
☐ Itemized Bills
☐ Laboratory Reports
☐ Medications
☐ Operative Reports
☐ Pathology Reports
☐ X-Ray Films
☐ X-Ray Reports
☐ *HIV/AIDS
☐ *Alcohol/Substance Use Disorder
☐ *Mental Health/Rehabilitation
☐ Other
_____
_____
_____
☐ Any and all

If you are requesting the release of alcohol/substance use disorder records, mental health treatment or rehabilitation records; or HIV/AID diagnosis or treatment records, this form ***must* also be accompanied by a valid and signed authorization permitting the release of such records. You may use the Geisinger Authorization (provided online at http://www.geisinger.org/patient-care/patients-and-visitors/medical-records) for this purpose.

I am requesting that the information be sent to the designated recipient in the selected form or format:

Recipient: ☐ Myself
☐ Other individual
Name: _____
Address: _____
_____
Phone: _____
Fax: _____
Email: _____

Format: ☐ MyGeisinger (pdf format)
☐ US Mail (paper format)
☐ CD (secure pdf format)
☐ Fax
☐ Email (you will receive a link or instructions to download)
☐ Other (Please specify)

IMPORTANT INFORMATION: I understand that if I ask Geisinger to disclose PHI to another individual or entity, that information may no longer be protected by Federal and State privacy laws, including HIPAA. I understand that Geisinger will make reasonable attempts to produce the documents in the format requested; however, if the records are not readily reproducible in that format, I understand Geisinger will call to discuss alternative delivery options. In certain limited circumstances, Geisinger may deny a request. If a request is denied, I understand I will be given a written explanation, and a description of steps I may take in response to the denial.

SIGNATURES

NOTE: IF PATIENT IS UNDER 14 YEARS OF AGE AND IS NOT EMANCIPATED MINOR THE PARENT OR GUARDIAN MUST SIGN. IF BETWEEN THE AGES OF 14-18 YEARS OF AGE, BOTH SIGNATURES ARE NEEDED.

Date/Time: _____ **Patient Signature**:_____

If patient is unable to sign authorization form because of physical condition or age, complete the following:
Patient is a minor or patient is unable to sign authorization because:_____

Date/Time: _____ **Signature**: _____ **Relationship**: _____
(Parent/legal or personal representative with authority under State law to make health care decisions for the patient)

*Throughout this document, the term "Geisinger" shall refer to those corporate affiliates within the health care system which are involved in the provisions of health care services and related support services. Geisinger is comprised of Geisinger Health ("GH") as parent and all subsidiary corporate entities.