PATIENT DIRECTED REQUEST FOR HEALTH INFORMATION/RECORDS

DCMC recognizes the patient's right to access to their health information/records as well as the right to direct the organization to send their health information to another designated person or entity. The patient's request to direct health information to another person must be in writing, signed, and clearly identify the designated person or entity. DCMC will accept any written request from a patient. While this form is ***not*** required, it may be used to simplify the process and ensure timely and accurate processing. Note that processing fees may apply.

PATIENT INFORMATION

_____

First Name, Middle Initial, Last Name (Previous Names) *Date of Birth*

_____

Address *Phone Number*

- ☐ Billing Records
- ☐ Emergency Department Reports
- ☐ Hospitalization Summary
- ☐ Diagnostic Imaging Films/X-rays
- ☐ Immunizations
- ☐ Operative/Procedure Reports
- ☐ Progress Notes
- ☐ Lab Reports
- ☐ _____
- ☐ _____

Dates of Service: _____

RECIPIENT INFORMATION

I am directing DCMC to disclose my health information/records to: ☐ Myself or ☐ To:

_____

Name & Address of Individual or Entity Directed to Receive Information

DELIVERY METHOD REQUESTED

☐ Us Mail To: _____

☐ E-Mail To: _____

Delivery by unencrypted/ unsecured e-mail could lead to unauthorized access by third party; patient accepts risk.

☐ Other: _____

FORMAT REQUESTED

☐ Paper ☐ Encrypted CD ☐ E-Mail ☐ Other: _____

_____

Signature of Patient/Personal Representative - Optional *Date Signed*

Date Received:	*Date Processed:*	*Processed By:*