Lovelace Health System

PATIENT REQUEST FOR HEALTH INFORMATION

PATIENT INFORMATION (PLEASE PRINT)			
Patient Name			
Address			
City/State/Zip			
Date of Birth	/ /	**Phone #**	

WHAT RECORDS DO YOU WANT?			
I understand that this information may include information relating to: AIDS, HIV, diagnosis/treatment of drug or alcohol abuse; mental, behavioral health, or psychiatric care.			
☐ Summary (doctor notes, emergency room record, test results, operations)			☐ Laboratory Reports
☐ Discharge Summary	☐ Emergency Room Record	☐ Radiology Reports	☐ Other
☐ History/Physical	☐ Operative Report(s)	☐ Radiology Images	
Date(s) of Service:			

HOW WOULD YOU LIKE YOUR RECORDS DELIVERED?		
☐ Paper:	☐ I will pick up in-person	☐ Mail To Home (address below)
☐ CD:	☐ I will pick up in-person	☐ Mail To Home (address below)
☐ Email:	I would like my copy sent to me electronically via e-mail using the following e-mail address: _____ **WARNING: I understand there is a level of risk that my PHI could be read or otherwise accessed by a third party while in transit and agree to receiving my PHI by unencrypted e-mail using the e-mail address above. My signature indicates I understand and accept the risk.** _____**(Signature of patient)**	
☐ Other		

WHERE DO YOU WANT YOUR RECORDS SENT?		
Lovelace should provide my records to: ☐ Myself ☐ My Personal Representative (indicated below):		
Recipient Name		Recipient Telephone #
Recipient Street Address	Recipient City, State Zip	Recipient Fax or Email (if applicable)

Lovelace recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.

_____ _____
Signature of Patient/Authorized Representative Date

_____ _____
Printed Name of Patient or Legal Guardian Relationship to patient, if other than self (attach appropriate legal documents)

Please Return Completed Form to: **HIM Department**
4101 Indian School Rd NE, Suite 110
Albuquerque, New Mexico 87110

For questions about completing this form please call #505-727-8195

For Hospital Staff use:

MR/Acct #: _____ ID Verified: _____

Processed by: _____ on _____ via _____