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**Patient Request for Health Information Form**

Slidell Memorial Hospital recognizes a patient’s right of access under HIPAA. There may be charges associated with processing a request and producing requested records.

Patient Information (Please Print)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: | Middle Initial: | | Last Name: | |  |
| Name at Time of Treatment (if different than above): | | | | | |
| Date of Birth (MM/DD/YYYY): | | Phone: | | E-mail (optional): | |
| Street Address: | | City: | | State: | Zip: |

**What records do you want? (Check appropriate boxes below):**

Date(s) of Service: / / through / /

Discharge Summary Emergency Room Records Operative/Procedure Reports Billing Records Test Results (X-Rays, Lab/Pathology Results) Please specify: Other (Immunization Records, Medication Lists) Please specify:

**How would you like your records delivered?**

Mail Delivery

Electronic (Email) Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Where do you want the information sent? (Fill in boxes below):

***Slidell Memorial Hospital***should provide my records to: Self Personal Representative (indicated below)

|  |  |
| --- | --- |
| Recipient Name: | Recipient Phone:  Recipient Fax: |
| Recipient Mailing Address: | Recipient E-mail (if applicable): |

Please print your name and sign below:

|  |  |
| --- | --- |
|  |  |
| **Name of Patient or Personal Representative (please print)** | **Relationship to Patient (please print)** |
|  |  |
| **Signature of Patient or Personal Representative** | **Date/Time** |

**Please return completed form to: Slidell Memorial Hospital, HIM Department, 1001 Gause Blvd., Slidell, LA 70458, Ph# 985-280-1706, Fax:985-280-8897**

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**For internal use by Slidell Memorial Hospital only:**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Patient Identification #:*** | ***Date Received:*** | ***Date Processed:*** | ***Processed By:*** |
| ***Fee Charged:*** | ***Were Records Reviewed On-site?*** | ***Date Reviewed:*** |  |