ESTES PARK HEALTH

Patient Request to Access Medical Records Form

555 Prospect Ave., Estes Park, CO 80517 Phone # 970-586-2317 Ext.2030 Fax # 970-586-8237
Email: medrecs@eph.org

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **LAST 4 OF SS#:** _____

ADDRESS: _____ **CITY/STATE/ZIP CODE:** _____ **PHONE NUMBER:** _____

I am the ____Patient____Guardian____Conservator____Designee ____ Surrogate decision maker with authority to use and disclose PHI. _____ Patient's Designated Representative, and **I am requesting access to (please check one)**:

☐ **View Records Only** ☐ Send Records via Encrypted Email ☐ Mail Records to address above

☐ **Obtain Copies of Records** ☐ Personal Pickup ☐ Other: _____

Date(s) of service to be released:_____

Purpose:

____ Further Medical Care ____ Personal Use ____ Workers' Comp
____ Insurance ____ Legal ____ Other: _____

Please mark information to be released:

____ History and Physical ____ Immunization Records ____ Problem List/Treatment Plan
____ Clinic Notes ____ Consultation ____ Medication List/Active
____ Laboratory Results ____ X-Ray Reports ____ Pathology Results
Other, please specify _____

I certify that this request to access this health information is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that EPH may not be able to grant access to certain types of information and information belonging to minors between the ages of 13 and 17 (as determined by applicable state and federal laws). I understand that, if I need to obtain hard copies, there may be a charge associated with such copies as allowed by law.

_____ _____ _____
Signature of Patient/Legal Representative Date Time

If Legal Representative, Print Name: _____ Relationship to Patient: _____

Office Use Only: MRN_____ CSN/Acct#:_____

Copied information delivered by means of:

☐ Personal Pickup ☐ Encrypted Email ☐ Mailed Records ☐ Other

Verification of Identity (Driver's License or other ID): _____

If signed by legal representative, indicate documentation:

☐ Death Certificate ☐ Power of Attorney ☐ Living Will ☐ Other: _____

Date Fulfilled: _____ Individual Who Fulfilled: _____

Note: EPH has a minimum charge of $16.50 for the first 10 pages copied plus $0.75 for pages 11-40 and $0.50 for each additional copy thereafter. There will be no charge for information sent from EPH to an insurance company for billing purposes. There will be no charge for information sent to a physician's office unless it exceeds 75 pages.

Form Created: 10/11/2019