Patient Request for Health Information

The undersigned patient or personal representative hereby requests:

☐ To obtain an electronic copy of the medical record or films on a CD, for the patient named below; or

☐ To obtain a paper copy of the medical record for the patient named below.

Patient Name _____Date of Birth_____

Address _____

City/State/Zip_____

Telephone _____ Fax Number _____
(Include area code) *(Include area code)*

For service dates from _____ to _____

Specific document/results/encounter requested _____

GCRMC will provide patients with access to the requested healthcare information provided there exist no grounds to deny the information. Pursuant to the Privacy Rule, GCRMC has 30 days to provide the hard copy documentation to the patient, but will make every effort to provide the information in a timely manner. GCRMC's HIM Department or Physician's office ***may*** be able to fulfill the request at the time it is made, but there may be instances where staff will need to arrange a pick-up date with the patient or send information by mail.

Print Name of Patient or Personal Representative _____
(If Personal Representative, include a description of authority to act for patient)

Patient or Personal Representative **Signature**: _____Date: _____

I agree to pay a fee for the coping (after the first 10 pages) and postage expenses associated with my request.

Return this **completed** form to GCRMC's Health Information Management Department.
If you have any questions, please call 575-443-7800

For GCRMC Use Only: Date that this request was received by GCRMC _____

Date of Disclosure: _____ MRN: _____

Request Disposition: _____ Approved _____ Denied

Gerald Champion
Regional Medical Center
Our Family Caring For Yours