



Patient Request for Access

Did you know you can view some of your medical record online via MyChart? For more information, go to <https://mychart.conehealth.com/MyChart/>. If you would like a copy of your medical record, please complete the form below.

I am a patient of Cone Health and my information is listed below:

Patient Name: _____ Date of Birth: _____
 Street Address: _____ Last 4 numbers of SSN: _____
 City, State, Zip: _____ Telephone: _____
 Email address: _____

I understand that, if I request my records to be e-mailed or faxed, this is not considered secure and my health information could be viewed by someone other than me.

I would like for **CONE HEALTH** to (choose one): _____ **give me a copy of my health information**
 _____ **send my records to:**

 (Name of Facility, Person, Company) (Street Address or PO Box, City, State, Zip Code)

 (Phone Number) (Fax Number)

 (E-mail Address)

I would like records released from a: _____ **CONE HEALTH HOSPITAL**
 _____ **CONE HEALTH MEDICAL GROUP PRACTICE** _____

I would like these dates of service to be released: _____

I want these parts of my record:

Hospital (check all that may apply): <input type="checkbox"/> Hospital Summary <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Record <input type="checkbox"/> History and Physical <input type="checkbox"/> Operative Reports <input type="checkbox"/> Laboratory reports <input type="checkbox"/> Radiology/X-Ray Reports <input type="checkbox"/> Other _____ <input type="checkbox"/> Entire record <input type="checkbox"/> Itemized Bill	Office/Clinic (check all that may apply): <input type="checkbox"/> Office/Clinic Summary <input type="checkbox"/> Office Visits <input type="checkbox"/> Physical Exam <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Other _____ <input type="checkbox"/> Entire Record <input type="checkbox"/> Itemized Bill	Behavioral Health/Sub. Abuse (check all that may apply): <input type="checkbox"/> Hospital/Discharge Summary <input type="checkbox"/> Assessments <input type="checkbox"/> Progress notes <input type="checkbox"/> Medications <input type="checkbox"/> Lab reports <input type="checkbox"/> Other _____ <input type="checkbox"/> Entire Record (Not including psychotherapy notes) <input type="checkbox"/> Itemized Bill
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I want these records as a (choose one):

- USB/CD
- Upload to MyChart account
- Paper copy
- Email

I want you to (choose one):

- Mail them
- Send them secure e-mail
- Fax them to: _____
- Prepare them to be picked up by: _____

As an alternative, you may schedule an appointment with your healthcare provider's office to see your record in person. Please note it may take up to 30 days to schedule the appointment or provide copies.

Signature: _____ Print Name: _____

Relationship to Patient: _____ Date: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this for the patient. (Written Proof May be Requested)