Office Use Only:
MRN#:_____
Completion
Date/Initials:_____

TOMAH MEMORIAL HOSPITAL/TOMAH HEALTH

Patient Health Information Access Request Form

MRN: _____

Patient Information: Today's Date: _____

_____

First Name MI Last Name

_____

Address

_____

Date of Birth Phone Number Previous name(s)

Request that Tomah Memorial Hospital/Tomah Health disclose my health information to:

Myself or _____

Name of Health Care Provider/Insurance/Attorney/Other

Delivery Method Requested:

Mail To: _____

Address City State Zip

Email Address: _____

Pick Up (include date to be picked up if applicable) _____

Format Requested (Fees may apply):

Non-encrypted CD Paper Other_____

Encrypted email Non-encrypted email (Requester was informed and understand the risks of receiving records via unsecured email and that personal health information could be accesses by a third party while in transit. Requestor still wants the records in this manner.)

Information to be Disclosed and Dates:

Hospitalization/Treatment Date(s): _____

Billing Records related to (specify):_____

Emergency department records

Hospital summary- a general abstract will be sent which includes discharge summary, H&P, consults, operative reports, labs, radiology reports, & ER.

Imaging Films (X-ray, CT, MRI)

Imaging Results

Immunizations

Lab Reports

Procedure Op Reports

Progress Notes/Updates

Other: _____

Patient/Personal Rep signature: _____

Tomah Memorial Hospital/Tomah Health will accept any written request from a patient for access to or copies of their own medical record. This form is not required. However, it will provide TMH/TH with all needed information to assure an accurate response.

12/2018