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

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 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 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 TH with all needed information to assure an accurate response.

10/2021