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 services 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.

I agree to pay a fee for the copying and postage expenses associated with my request.

Name of Patient or Personal Representative *(PLEASE PRINT)*_____

Signature of Patient or Personal Representative: _____Date: _____
(If Personal Representative, include a description of authority to act for patient)

Return this **completed** form to the Department or Physician's Office from which services have been provided, or 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 _____

Request Disposition: _____ Approved _____ Denied Date of Disclosure_____

Gerald Champion Regional Medical Center
Our Family Caring For Yours

GCRMC Form# MRHIPAA4 5-12