Patient Request for Health Information

Patient Information (Please Print)

First Name:	Middle Initial	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional)	
Street Address:	City:	State:	Zip:

What records do you want? (Check appropriate boxes below):

Date(s) of Service: ___/___/___ through ___/___/___

- ☐ Discharge Summary
- ☐ Emergency Room Records
- ☐ Operative/Procedure Reports
- ☐ Test Results: X-rays
- ☐ Lab/Pathology
- ☐ Other: _____
- ☐ Other (Immunization Records, Medication Lists) Please specify: _____

How would you like your records delivered?

- ☐ Paper
  - ☐ Mailed to your home (Specify address if different from above).
  - ☐ In-Person Pickup
- ☐ Electronic (CD, email, other) Please specify: _____

(***Note**: If I elect to have my records emailed to an e-mail address of my choice I am aware that this is an **unsecure** method of transmitting my personal health information).*

Where do you want the information sent? (Fill in boxes below):

Sweetwater Hospital/Sweetwater Professional Building should provide my records to:

Self (At above address) Personal Representative (indicated below)

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient e-mail address (if applicable):

Please print your name and sign below:

Name of Patient or Personal Representative (please print)	Relationship (please print)
Signature of Patient or Personal Representative	Date/Time

Please return completed form to:

	E-mail: Fax:
	Questions?

SHA Sweetwater Hospital Association

Sweetwater Hospital Association and Sweetwater Professional Offices recognize a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.