Community Health Network

PATIENT IDENTIFICATION

PATIENT MEDICAL RECORDS ACCESS REQUEST

Not to be used for VERBAL communication

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH:_____ Last 4 digits of SS#: _____

Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____

Clinic/Hospital/ Healthcare Provider-

(**Who** has the information you want released? Please list the specific Hospital and/ or clinic)

LOCATION of service provided. Please check all that apply,

COMMUNITY HOSPITAL:	**COMMUNITY SURGERY CENTER:**	**OTHER:**
☐ Anderson	☐ East	☐ Cancer Centers
☐ East	☐ Hamilton	☐ Community Fairbanks Behavioral Health
☐ Heart & Vascular (a facility under CHE)	☐ Howard	☐ Inpatient ☐ Outpatient
☐ North	☐ North	☐ Community Fairbanks Behavioral Health Howard
☐ South	☐ Northwest	☐ Home Health
☐ Westview (a facility under CHE)	☐ Plus	☐ Imaging Centers
☐ Howard Regional Health	☐ South	☐ Medchecks
☐ Howard Specialty Hospital	☐ Digestive Centers Anderson	☐ Physical Therapy Offices
	☐ Endoscopy Center Indianapolis	☐ Physician Network

Physician_____ Practice Name_____

Receiving Party

(**Where** and to whom do you want the records sent?)

☐ Me ☐ Other

NAME: _____

Address: _____ City: _____ State: _____ Zip: _____

Day Phone: _____ Fax Number _____

Email Address: _____

Information to be Released

(**What** do you want? Check the appropriate box(es).)

Disclosure will include (check all that apply):

☐ Consultation Report	☐ Discharge Summary/Notes	☐ Emergency Record(s)	☐ History and Physical Report	☐ Forensic Photos	☐ Entire Record
☐ Immunization/Allergy Records	☐ Laboratory/Pathology Report	☐ Medication Report	☐ Office Visits	☐ Operative Report	☐ Communicable Diseases
☐ Progress Notes/Clinic Notes	☐ Films/Images	☐ Therapy Records	☐ X-ray/Radiology Report	☐ Forensic Consult	☐ Billing Records
☐ Substance Abuse Records	☐ Mental Health Records	☐ BH Treatment Plan	☐ BH Diagnosis	☐ BH Evaluation/Assessment	

☐ Other records specify record type(s) _____

Date(s) of Service _____ Illness or injury _____

Release Instructions

(**How** and **When** do you want the information?)

Date information is needed:_____ (NOTE: PLEASE ALLOW 30 DAYS FOR PROCESSING)

Release Method/Format requested: (check one)

☐ MyChart ☐ Paper ☐ CD/DVD ☐ Fax __

☐ Secured e-mail _____

☐ Unsecured e-mail _____ ***(E-mail is not a secure form of communication. See page 2 for details)***

☐ I have read the warning on page 2 and wish to receive my records from Community Health Network via unsecured e-mail.

_____

Signature for Unsecured Email

☐ Other* _____

*Requests for other methods of delivery will be reviewed on a case by case basis

_____ _____ _____

Patient/Legal Guardian Signature | Date/Time | Authority to act on behalf of patient (attach document)

Community Health Network

DIRECTIONS FOR COMPLETION OF THIS FORM

Patient Name: _____ Date of Birth: _____

Patient Information: Complete the entire section which identifies clearly and legibly all of the demographic information specific to the patient (individual who information is being requested for).

Clinic/Healthcare Provider: Identify which Community Health Network facility you are seeking information from (or to be sent to). **Please be specific** in your request. For example, when choosing Community Physician Network please add either the name of the provider or the practice name you are requesting. If you do not identify a specific facility, records may be provided to **ALL** Community Health Network facilities where you have received care. Please see www.eCommunity.com for a listing of Community Health Network locations and names.

Receiving Party: Identify the full name/business, address, phone and contact information with the name of the individual who is to receive the information. *Please allow 30 days for all requests to be processed and sent to the recipient.*

Information Requested: This section gives us the instructions for what information you want released.

Release Instructions: This tells us how you would like your information delivered. We can print the documents, mail, secure email, or create a CD. If we are unable to provide in the format desired we will contact you to make other arrangements.

Please read the warnings below and sign on the front of the page if you agree to unsecure e-mail.

- Any e-mail (including those claiming to be private) is often compared to a postcard in that anyone who comes in contact with it can read it.
- E-mail may be read when it is stored on internet service provider servers.
- E-mail is hard to destroy because it is archived/stored on e-mail servers.
- Medical records contain extensive data with monetary value and can be bought and sold on "the dark web" for medical identity theft and other illicit purposes.

Contact Information

Community Health Network
Health Information Management-ROI
1500 North Ritter Avenue
Indianapolis, IN 46219

Phone: 317.355.5802
Fax: 317.351.7728

For any questions/follow-up regarding your request please e-mail **releaseofinformation@eCommunity.com**

To submit a request for records please e-mail to **ROIRequests@eCommunity.com**