LeConte Women's Healthcare Associates
Covenant HEALTH

PATIENT REQUEST FOR MEDICAL RECORDS

If any section is **INCOMPLETE**, this form may be **invalid**. You may be **charged for copies** in accordance with state law.

Patient Name:_____ Social Security Number: _____

Date of Birth:____/____/_____ Phone:_____ Med Rec #:_____ EDD*:_____

LeConte Women's Healthcare Associates
740 Middle Creek Road, Suite 200, Sevierville, TN 37862, PH: 865-908-9888, FAX: 865-331-1976, Email: pnchim@covhlth.com
Is authorized to:

☐ Release medical records to or

☐ Obtain medical records from

☐ Myself or ☐ Full Name of Provider, Clinic, or Hospital: _____

Address: _____ Phone: _____

City, State, ZIP_____ FAX:_____

Method of Delivery / Pick up / Special Instructions

☐ Pick up ☐ Fax to: _____

☐ Mail to the following address: _____

☐ Email (if requested the patient/patient authorized representative consents to receiving protected health information via email and understands that records and messages sent through this type of communication may not be secure.)

Special Instructions / Email Address: _____

Information to be Disclosed

The medical record information to be disclosed includes only those items checked below, with respect to services provided on or around _____. I understand this information may include, but is not limited to, information related to psychiatric or psychological treatment, treatment for drug and/or alcohol use, or information relating to Acquired Immune Deficiency Syndrome/HIV or other sexually transmitted diseases.

☐ Entire medical record, other than psychotherapy notes (separate authorization required for psychotherapy notes)

OR - the following parts of the medical record:

☐ Demographics, Current Insurance and Policy Holder Information ☐ Last PAP and OB/GYN Notes on or around _____

☐ Lab reports on or around_____ ☐ Operative reports on or around _____

☐ Ultrasound Reports on or around _____ ☐ Other: _____

Certification

☐ I certify I am the Patient and the identification that I have provided are true and correct.

☐ I certify I am the Patient's Authorized Representative and that the identification and proof of authority I provided are true and correct. My relationship to the patient is that of: _____.

Signature: _____ Printed Name: _____

Date: _____ Time: _____ Authority Document: _____

For Provider Use Only. Date Received: _____ Date Processed: _____

How was identity verified? _____ Copy made? ☐ Yes ☐ No

How was authority verified? _____ Copy made? ☐ Yes ☐ No

By: _____ Title: _____ Release Incomplete: _____

☐ Verbal / Phone Consent obtained from: _____

Account #'s Released: _____

*If pregnant. Provide patient/patient representative with copy of form. 5.5.2022

PATIENT REQUEST FOR MEDICAL RECORDS

THIS PAGE IS FOR STAFF USE ONLY:

1. Advise patient to fill out this form completely. We are not allowed to ADD or DELETE information on the form later.
2. NOTE: Hospital, Surgery, and Delivery Notes must be requested from the facility where service was performed. **Do not** request these records from the physician/provider that performed the services.
3. Provide one form per request (i.e., obtain separate *Patient Request for Medical Records* forms for each hospital, provider, or clinic from which records are requested).
4. Review the form(s) for completeness before the patient leaves the office.
5. Staff member receiving the form should complete appropriate sections of page 2, sign, and list title; i.e., *Jane Doe, MD* or *John Law, Patient Acct Rep*.

For Staff Use Only:

Date Received: _____

Complete the applicable section below based on who signed the *Patient Request for Medical Records* form.

Patient Signed Form

Mark below how patient identity was verified. One photo ID is required if the patient signed the form. Identification marked below must be scanned into the patient's EMR chart for the *Patient Request for Medical Records* to be valid. Check to see if ID has already been scanned.

[ ] Photo ID scanned in EMR
[ ] Passport scanned in EMR
[ ] EMR Photo
[ ] Employer Photo ID scanned in EMR
[ ] Driver's License scanned in EMR
[ ] Signature Verification (must be verified by two staff members)
[ ] Other Photo ID scanned in EMR; specify: _____

Legal Representative Signed Form

Mark below how legal representative's identity was verified. Two forms of identification are required, and one must be a photo ID. Identification must be scanned into the patient's EMR chart for *Patient Request for Medical Records* to be valid. Check to see if ID has already been scanned.

[ ] Legal Representative Driver's License
[ ] Legal Representative Social Security Card
[ ] Legal Representative Passport
[ ] Legal Representative Birth Certificate
[ ] Legal Representative Employer Photo ID
[ ] Other ID, please describe:_____

Mark below how the legal representative's authority to sign the form on behalf of the patient was verified. The document marked below must be scanned into the patient's EMR chart for the *Patient Request for Medical Records* to be valid. Check to see if legal documents have already been scanned.

[ ] Patient Birth Certificate
[ ] Marriage Certificate
[ ] Guardianship Papers
[ ] Other Legal Document, please describe: _____
[ ] Attorney-In-Fact Appointment Papers

Complete the next two sections on all forms.

Copy of *Patient Request for Medical Records* provided to person who signed form. [ ] Yes [ ] No [ ] Signer refused copy of form

Signature:_____ Title:_____