MAGRUDER HOSPITAL
It's How We Care

Patient Request for Health Information

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):

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

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

- ☐ ED/UC Record
- ☐ Laboratory Result(s)
- ☐ Radiology Report(s)
  - ○ _____
  - ◉ CD of Images
- ☐ Pathology
- ☐ Sleep Study
- ☐ Office Records
  Provider:_____
- ☐ Operative Report
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Billing Records/Itemized Statements
- ☐ Therapy Records
- ☐ Photographs
  _____
- ☐ Medication Profiles (including diagnosis information attached to Prescriptions and Re-fill information)
- ☐ Other_____

How would you like your records delivered?

- ☐ Paper
  - ◉ Mail to _____
  - ○ Patient to Pick up
- ☐ Email *NOTE: Please understand emails can be intercepted during transmission, and that unencrypted messages (and any attachments) can be read, and potentially copied and forwarded, by anyone. Unencrypted emails can also be easily viewed by someone other than the recipient if, for example, the patient accesses their messages via a smart phone or tablet.*

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

Magruder Hospital (including **Magruder Medical Group** and **The Pharmacy** at Magruder Hospital) should provide my records to:

☐ Self ☐ Personal Representative (Indicated below)

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

Please print your name and sign below:

(Please Print) Name of Patient or Personal Representative	Relationship
Signature of Patient or Personal Representative	Date/Time