Patient Request for Access

Did you know you can view some of your medical record online via MyChart? For more information, go to https://mychart.conehealth.com/MyChart/. If you would like a copy of your medical record, please complete the form below.

I am a patient of Cone Health and my information is listed below:

Patient Name: ________________________________ Date of Birth: __________________________

Street Address: ________________________________ Last 4 numbers of SSN: _________________

City, State, Zip: ________________________________ Telephone: ___________________________

Email address: ____

I understand that, if I request my records to be e-mailed or faxed, this is not considered secure and my health information could be viewed by someone other than me.

☐ **I would like for CONE HEALTH to** (choose one): ______ **give me a copy of my health information**
______ **send my records to:**

____
(Name of Facility, Person, Company) (Street Address or PO Box, City, State, Zip Code)

____
(Phone Number) (Fax Number)

____
(E-mail Address)

I would like records released from a: _____**CONE HEALTH HOSPITAL**
_____**CONE HEALTH MEDICAL GROUP PRACTICE** ______________________

I would like these dates of service to be released: ____

I want these parts of my record:

Hospital (check all that may apply):	**Office/Clinic (check all that may apply):**	**Behavioral Health/Sub. Abuse (check all that may apply):**
☐ Hospital Summary ☐ Discharge Summary ☐ Emergency Record ☐ History and Physical ☐ Operative Reports ☐ Laboratory reports ☐ Radiology/X-Ray Reports ☐ Other_______________________	☐ Office/Clinic Summary ☐ Office Visits ☐ Physical Exam ☐ Laboratory Reports ☐ Radiology Reports ☐ Other____________	☐ Hospital/Discharge Summary ☐ Assessments ☐ Progress notes ☐ Medications ☐ Lab reports ☐ Other ______________________
☐ Entire record ☐ Itemized Bill	☐ Entire Record ☐ Itemized Bill	☐ Entire Record (Not including psychotherapy notes) ☐ Itemized Bill

I want these records as a (choose one):

☐ **USB/CD**
☐ **Upload to MyChart account**
☐ **Paper copy**

I want you to (choose one):

☐ **Mail them**
☐ **Prepare them to be picked up by:** ____________
☐ **Fax them to:** __________________________

As an alternative, you may schedule an appointment with your healthcare provider's office to see your record in person. Please note it may take up to 30 days to schedule the appointment or provide copies.

Signature: ______________________________ **Print Name:** ______________________________

Relationship to Patient: ____ **Date:** ________________

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this for the patient. (Written Proof May be Requested)