CONE HEALTH

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 emailed 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)*

_____
(Email Address)

I would like records released from a:
- ☐ **Cone Health hospital**
- ☐ **Cone Health Medical Group practice (specify):** _____

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

I want these parts of my record:

Hospital (check all that apply):	**Office/Clinic (check all that apply):**	**Behavioral Health (check all that apply):**
☐ Hospital Summary	☐ Office/Clinic Summary	☐ Hospital/Discharge Summary
☐ Discharge Summary	☐ Office Visits	☐ Assessments
☐ Emergency Record	☐ Physical Exam	☐ Progress Notes
☐ History and Physical	☐ Laboratory Reports	☐ Medications
☐ Operative Reports	☐ Radiology Reports	☐ Laboratory reports
☐ Laboratory reports	☐ Other: _____	☐ Other: _____
☐ Radiology/X-ray Reports		
☐ Other: _____	☐ Entire Record	☐ Entire Record (not including psychotherapy notes)
	☐ Itemized Bill	☐ Itemized Bill
☐ Entire Record		
☐ Itemized Bill		

I want these records as (choose one):
- ☐ **USB/CD**
- ☐ **Upload to MyChart account**
- ☐ **Paper copy**
- ☐ **Email:** _____

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 that it may take up to 30 days to schedule the appointment or provide copies.

Signature: _____ Printed 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.)

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