St. Luke's HOSPITAL
101 Hospital Drive
Columbus, NC 28722

Patient Request for Access

1PRFA

If you would like a copy of your medical record, please complete the form below.

I am a patient of St. Luke's Hospital and my information is listed below:

Patient Name: _____ Date of Birth: _____

Street Address: _____ Last 4 numbers of SSN: _____

City, State, Zip: _____ Telephone: _____

Email address: _____

By providing your email address, you acknowledge and accept the risks outlined in Guidelines for E-mail with Patients, provided separately if applicable.

I would like for St. Luke's Hospital 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 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_____ ☐ Entire record ☐ Itemized Bill	☐ Office/Clinic Summary ☐ Office Visits ☐ Physical Exam ☐ Laboratory Reports ☐ Radiology Reports ☐ Other_____ ☐ Entire Record ☐ Itemized Bill	☐ Hospital/Discharge Summary ☐ Assessments ☐ Progress notes ☐ Medications ☐ Lab reports ☐ Other _____ ☐ Entire Record (Not including psychotherapy notes) ☐ Itemized Bill

I want these records as a (choose one):
CD **Flash Drive**
E-mail
Paper copy
Other: _____

I want you to (choose one):
Mail them
Send them secure e-mail
Fax them to: _____
Prepare them to be picked up by: _____

As an alternative, you may schedule an appointment with the Health Information Management 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)

For Hospital Use Only: Completed by: _____
Name Date