BJC HealthCare
Christian Hospital

11133 Dunn Road
St. Louis, MO 63136

314-653-5113 FAX: 314-653-4154

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION BY INDIVIDUAL PATIENTS

Individual (Patient) Name: _____

Patient's Date of Birth: _____ Social Security # (or last 4 digits) _____

Patient Address: _____

Telephone Number: (Home) (_____) _____ (Cell) (_____) _____

I request only the following information to be released:

- ☐ Abstract (includes all * documents)
- ☐ Emergency Report*
- ☐ Discharge Summary*
- ☐ History & Physical*
- ☐ Progress Notes*
- ☐ Consults*
- ☐ Operative Report*
- ☐ Pathology Report*
- ☐ Laboratory* (specify) _____
- ☐ Itemized Billing Statement
- ☐ Good Faith Estimate
- ☐ Other (specify) _____
- ☐ X-Ray Report*
- ☐ Mammogram Report*
- ☐ Cardiac Cath Lab Reports*
- ☐ EKG
- ☐ Medication Report
- ☐ Advanced Directive
- ☐ Expiration Documents

Films

- ☐ X-Ray Films
- ☐ Cardiac Cath Lab Cine Film
- ☐ Mammogram Film

Date(s) of Treatment: _____

Would you like your records to be mailed to the above address: ☐ Yes ☐ No

To another address as indicated below: ☐ Yes ☐ No

_____

Would you like records sent electronically (if possible) to yourself or a designated individual? ☐ Yes ☐ No

To whom? _____ Email address: _____

_____ _____

Signature of Individual or Personal Representative Date

Processing Your Requested Information:

You may be charged a fee for the copying of requested health information. This fee will be based on the cost of the labor and supplies involved in copying the requested health information and the postage for mailing the copies to you. If you do not want the requested records mailed, you may contact our office after 30 days to pick-up your records. Response to your request for health information will be within 30 days of receipt of your request. If we require additional time to respond to your request, we will contact you to inform you of this extension of time.

We appreciate your patience while we process your request.