



**REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION  
BY INDIVIDUAL PATIENTS**

Individual (Patient) Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Telephone Number: (H) ( ) \_\_\_\_\_ (W) ( ) \_\_\_\_\_

I request only the following information to be released:

- All Records
- Progress/Office Notes
- X-Ray/Imaging Reports
- Diagnostic Test Results
- Pathology Report
- Laboratory (specify) \_\_\_\_\_
- Other (specify) \_\_\_\_\_
- Medication List
- Procedures
- Immunization/Vaccine Summary
- EKG
- Itemized Billing Statement

Provider Name: \_\_\_\_\_

Date(s) of Treatment: \_\_\_\_\_

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

To another address (please indicate) \_\_\_\_\_

Would you like your records transmitted electronically (if possible) to a designated individual? Yes No

To whom? \_\_\_\_\_ What electronic address? \_\_\_\_\_

Signature of Individual or Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

**Processing Your Requested Information:**

BJC Medical Group may charge 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. BJC Medical Group will respond to your request for health information within 30 days of our 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.

**BJC Medical Group Use Only:** Request Date: \_\_\_\_\_

Date Access Granted: \_\_\_\_\_

Date Access Denied: \_\_\_\_\_

(Must Complete Denial of Access Form)