hillcrest HealthCare System	☐ **Hillcrest Medical _____ (indicate location)** ☐ **Bailey Medical Center** ☐ **Utica Park Clinic _____ (indicate location)** ☐ **Oklahoma Heart Institute** ☐ **Tulsa Spine and Specialty**

PATIENT INFORMATION (PLEASE PRINT)			
Patient Name			
Address			
City/State/Zip			
Date of Birth	/ /	**Phone #**	

WHAT RECORDS DO YOU WANT?	
I understand that this information may include information relating to: AIDS, HIV, diagnosis/treatment of drug or alcohol abuse; mental, behavioral health, or psychiatric care.	
☐ Summary (doctor notes, emergency room record, test results, operations) ☐ Discharge Summary ☐ Emergency Room Record ☐ Radiology Reports ☐ History/Physical ☐ Operative Report(s) ☐ Radiology Images	☐ Laboratory Reports ☐ Other
Date(s) of Service:	

HOW WOULD YOU LIKE YOUR RECORDS DELIVERED?		
☐ Paper:	☐ I will pick up in-person	☐ Mail To Home (address below)
☐ CD:	☐ I will pick up in-person	☐ Mail To Home (address below)
☐ Email:	I would like my copy sent to me electronically via e-mail using the following e-mail address: _____ **WARNING: I understand there is a level of risk that my PHI could be read or otherwise accessed by a third party while in transit and agree to receiving my PHI by unencrypted e-mail using the e-mail address above. My signature indicates I understand and accept the risk.** **_____(Signature of patient)**	

WHERE DO YOU WANT YOUR RECORDS SENT?		
Hillcrest Health System should provide my records to: ☐ Myself ☐ My Personal Representative (indicated below):		
Recipient Name		Recipient Telephone #
Recipient Street Address	Recipient City, State Zip	

Hillcrest Hospital / Utica Park Clinic recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.

_____ _____

Signature of Patient/Authorized Representative Date

_____ _____

Printed Name of Patient or Legal Guardian Relationship to patient, if other than self (attach appropriate legal documents)

Please Return Completed Form to:

HIM Department
1120 S Utica Ave
Tulsa, OK 74104
Fax 918-550-6576

For questions about completing this form please call 918-579-2100

For Hospital Staff use:

MR/Acct #: _____ID Verified: _____

Processed by: _____ on _____ via _____

Notes:_____