Facility: ___________________________
Department Name: ___________________
Address: ___________________________

& Affiliates

Phone #:_____________________________
Fax #: ______________________________

**PATIENT/PERSONAL REPRESENTATIVE REQUEST TO INSPECT AND/OR OBTAIN PHOTOCOPIES OF HEALTH INFORMATION**

Request is hereby made for access to ☐ **medical** ☐ **mental health** information regarding:

Patient's name:_________________________________________ Date of Birth: __________________
Address:_____________________________________________________________________________
City/State/Zip Code: __________________________________________________________________
Patient's daytime phone (       ) - _______________________________________________________

**What type of access are you requesting?**

| | |
|---|---|
| MyChart | Upload to MyChart free. Available for 30 days within MyChart. Download or print this information to a secure location prior to the end of 30 days for ongoing access. |
| View | You will be notified within 10 days on how to schedule an appointment with our staff. When viewing, you may request items for copying. |
| Electronic Copy | You should receive notification within 30 days from our release of information service, Verisma, of cost of the copies. |
| Paper Copy | You should receive notification within 30 days from our release of information service, Verisma, of cost of the copies. ***PLEASE CHECK HERE ☐ IF YOU NEED TO PICKUP YOUR RECORDS.*** |

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