DELTAHEALTH
Northwest Regional

AUTHORIZATION TO USE AND DISCLOSURE PROTECTED HEALTH INFORMATION

Patient Information (Please Print)					
First Name:	Middle Initial:	Last Name:			
Name at Time of Treatment (if different than above)					
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):			
Street Address:		City:		State:	Zip:
I am requesting my records from:					
Facility Name:		E-mail:			
Address:		Fax:			
City:		State:		Zip:	

What records do you want? (Check appropriate boxes below):

Date(s) of Service: ________________________ through __________________________

☐ Progress Notes ☐ Emergency Room Record ☐ Discharge Summary ☐ History and Physical

☐ Consultation(s) ☐ Lab Reports ☐ Pathology Report ☐ Operative Note(s)

☐ Imaging/ / X-Ray Reports ☐ Imaging / X-Ray Films ☐ Entire Record ☐ Fetal Heart Monitor Strips

Sensitive Information: ☐ Alcohol Abuse ☐ Drug Abuse ☐ Communicable diseases, including HIV status

☐ Genetic Testing ☐ Psychiatric/Behavioral Diagnoses

☐ Other (specify): ____

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How would you like your records delivered?

☐ Paper

☐ Electronic: ☐ Email (I understand that there is a risk to me when my information is transmitted via an unsecured e-mail system, and the information could be accessed by a third party during the transmission process. By checking the box to request E-mail delivery I accept this risk.)

☐ USB or CD

If mailing, where do you want the information sent? (Fill in boxes below):

Please provide my records to: ☐ Myself ☐ Personal Representative (indicated below) ☐ Other Third Party

Recipient Name:	Recipient Phone:	Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (if applicable):	

Please print your name and sign below:	
Name of Patient or Personal Representative (please print)	**Relationship (please print)**

Patient's Signature or Legal Representative:			Date:	Time:
Relationship to Patient / Authority to Act on Patient's Behalf:	Interpreter, if Utilized:		Date:	Time:
Signature of Witness:	Date:	Time:	Expiration Date or Event:	

This Healthcare Facility 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.