Patient Request for Health Information

Did you know you can request and access your medical records online through your patient portal?
Visit: https://my.atriumhealth.org.

(One Patient Per Form)

Patient Name: ______________________ Date of Birth: ______________________

Street Address: ______________________ City, State, Zip: ______________________

Telephone: ______________________ Email: ______________________

Treatment Facility/Physician: ______________________

Treatment Dates: ______________________

Information Requested (select all that apply):

Medical Records		Imaging (requires CD format)	Billing
☐ Facility Summary (Includes all items in **bold**)		☐ Radiology Images (X-Ray/CT/MRI/US)	☐ Itemized Bill(s)
☐ **Discharge Summary**	☐ **Pathology Reports**	☐ Cardiology Images (Echo/Cath Lab)	☐ UB04 Form
☐ **History & Physical**	☐ **Radiology Reports**	☐ Neurology Images (EEGs)	☐ CMS 1500 Form
☐ **Consultation Reports**	☐ **Immunizations**	☐ Fetal Ultrasound Images	☐ Other Billing: ______
☐ **Office/Progress Notes**	☐ Sleep Study Reports	☐ Other Imaging: ______	
☐ **Emergency Record**	☐ Entire Medical Record		
☐ **Operative Reports**	☐ Other ______		
☐ **Laboratory Reports**			

Send my requested information to:

☐ Myself

☐ Other: ______________________ ______________________

Name of Facility, Person, Company — Street Address or PO Box, City, State, Zip Code

______________ ______________ ______________

Phone Number — Fax Number — Email Address

Requested Form/Delivery Method: *(Fees may apply)*

By Mail:	Electronically:	Other:
☐ Paper Copy	☐ Encrypted Email	☐ In Person Pick-up at: ______
☐ CD	☐ Patient Portal	☐ Paper ☐ CD

I understand the information to be disclosed may include information regarding genetic testing, genetic services and family medical history, mental health/developmental disabilities, Substance Use Disorder, HIV Test results and AIDS/AIDS-related illness.

______________________ ______________ ________ ________

Parent or Legal Representative Signature — Relationship — Date — Time

____

Print Name

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign. Supporting documentation may be required.

Minor Authorization: If a minor consented to treatment by a licensed physician for pregnancy, sexually transmitted diseases, outpatient behavioral or mental health care, or outpatient treatment for controlled substances or alcohol without parental consent, the minor may sign this authorization. If the minor is receiving substance use disorder treatment with parental or guardian consent, both the minor and the parent or guardian may sign this authorization.

______________________ ________ ________

Signature of Minor — Date — Time

____

Print Name

Atrium Health

Patient Label Box