

Division: NC/GA Division	Area-Entity: All	Dept.: Health Information Management
Origin Date: 06/01/2019	Effective Date: 02/27/2026	

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 <input type="checkbox"/> Facility Summary (Includes all items in bold) <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Pathology Reports <input type="checkbox"/> History & Physical <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Consultation Reports <input type="checkbox"/> Immunizations <input type="checkbox"/> Office/Progress Notes <input type="checkbox"/> Sleep Study Reports <input type="checkbox"/> Emergency Record <input type="checkbox"/> Entire Medical Record <input type="checkbox"/> Operative Reports <input type="checkbox"/> Other _____ <input type="checkbox"/> Laboratory Reports	Imaging (requires CD format) <input type="checkbox"/> Radiology Images (X-Ray/CT/MRI/US) <input type="checkbox"/> Cardiology Images (Echo/Cath Lab) <input type="checkbox"/> Neurology Images (EEGs) <input type="checkbox"/> Fetal Ultrasound Images <input type="checkbox"/> Other Imaging: _____	Billing <input type="checkbox"/> Itemized Bill(s) <input type="checkbox"/> UB04 Form <input type="checkbox"/> CMS 1500 Form <input type="checkbox"/> Other Billing: _____
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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: <input type="checkbox"/> Paper Copy <input type="checkbox"/> CD	Electronically: <input type="checkbox"/> Encrypted Email <input type="checkbox"/> Patient Portal	Other: <input type="checkbox"/> In Person Pick-up at: _____ <input type="checkbox"/> Paper <input type="checkbox"/> CD
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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