PATIENT REQUEST FOR ACCESS TO DESIGNATED RECORD SET

In some areas, Providence Health & Services and Affiliates may store patient records separately for hospitals. We would be glad to fax a copy of this form to other facilities upon request.

You may attach an additional page if more room is needed than provided on the request form.

If you are requesting records for a deceased patient please contact the Central Release of Information Department to obtain an Affidavit of Surviving Spouse/Next of Kin and further directions.

Please forward this form to the hospital where you were seen. If you were seen at multiple facilities or are unsure of the appropriate contact information, you may forward the request to:

Providence Holy Cross Medical Center
Dept: Release of Information
501 S. Buena Vista St
Burbank, CA 91505
Phone: (818) 847-3801
Fax: (818) 847-3810

Important: Providence Health & Services and Affiliates no longer prints or releases patient social security numbers unless required for billing. However, social security numbers may be included in patient records that is more than a few years old. The information you are requesting may include your social security number.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Providence Health & Services and its Affiliates do not discriminate on the basis of race, color, national origin, sex, age, or disability in their health programs and activities.

ATTENTION: If you do not speak English, you have at your disposal free language assistance services. Call (888) 311-9127 (TTY: 711).
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (888) 311-9127 (TTY: 711).
注意：如果您講中文，我們可以給您提供免費中文翻譯服務, 請致電 (888) 311-9127 TTY: 711).

Providence

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Patient's Name: _____ DOB: _____

Prior Name(s) Used: _____ Contact Phone: _____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Patient's Email: _____

Please disclose my records to: Myself at the address above ☐ or the following recipient ☐

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

Please send my records via: ☐ MyChart ☐ Email ☐ Disc ☐ Paper ☐ Fax

I am requesting information from the following facility(s):

List Hospital(s) or Provider Name(s)	AND/OR List Clinic(s) or Provider Name(s)

For the range of dates from: _____ to: _____

Information to be disclosed:

☐ History & Physical
☐ Operative Report
☐ Diagnostic Report (lab, x-ray, EKG, etc.)
☐ Other (specify): _____
☐ Discharge Summary
☐ Emergency Department Report
☐ Progress Notes
☐ Last 2 years only

Fees may be associated with this request. Some records are unavailable to receive via MyChart.

Patient Signature: _____ Date: _____
(Print form and sign by hand)

Representative Name: _____ Date: _____

Representative Signature: _____ Relation to Patient: _____
(Print form and sign by hand. Please include supporting documentation.)