MORROW COUNTY HEALTH DISTRICT
Excellence in Healthcare

Patient Request for Health Information

Patient Information (Please Print)

Name (First, Middle, Last):		Date of Birth (MM/DD/YYYY):	
Street Address:	City:	State:	Zip:

Which records do you want? Please check appropriate boxes below.

Date(s) of Service: ____/____/____ through ____/____/____

☐ Billing Records
☐ Discharge/Visit Summary
☐ Emergency Room Records
☐ Procedure Reports
☐ Other (Immunizations, Medications) - Please specify: _____
☐ Test Results (X-Ray, Lab) - Please specify: _____

How would you like to receive your records?

☐ Paper
☐ Secured Email
☐ Unsecured Email
☐ Portal
☐ USB
☐ CD
☐ Other - Please specify: _____

Please keep in mind that information sent by unsecured email is vulnerable. Although it is unlikely, there is a possibility that the information could be intercepted and read by other parties besides the person to whom it is addressed.

Please provide my records to:

☐ Self
☐ Personal Representative

Please provide my records by:

☐ Mail
☐ Fax
☐ Pick Up
☐ Electronic Delivery

Recipient Name:	Relationship (If Personal Representative)
Mailing Address:	Phone:
Email:	Fax:

_____ _____

Signature (individual or personal representative) Date

Morrow County Health District recognizes a patient's right under HIPAA to access copies of their health information. There may be charges associated with processing a request and producing requested records.