

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

E-Mail Address (Optional): \_\_\_\_\_ Phone: \_\_\_\_\_

**I am requesting a copy of the following records (check only those that apply):**

- My full clinical medical record (please check below if applicable):  
 I would also like a copy of my billing records (or I would only like my billing records).

**OR - (If neither of the above are checked, check all that apply)**

- Discharge Instructions     Presence in Treatment Letter     Lab reports/test results  
 Discharge Summary Report (includes Psychiatric Evaluation, Discharge Summary, Discharge Instructions, Medication List)  
 Other – please describe: \_\_\_\_\_

**Covering the period of health care from:**

Latest visit    **OR**     All dates of encounters/visits    **OR**     Specific date(s): \_\_\_\_\_ to \_\_\_\_\_

**I request my records be sent to:**

Myself, as indicated below;    **OR**     (if request is limited to electronic health record information) the following identified recipient:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ E-Mail Address (if applicable): \_\_\_\_\_

**How would you like your records delivered and in what format? (check one)**

- Secure (Encrypted) E-mail     Unsecure (Unencrypted) E-mail  
 Paper Copies     Other (describe): \_\_\_\_\_

*For Paper Copies:*

- Mail at the address indicated above; or  
 In-Person Pickup at the identified Bournewood facility: \_\_\_\_\_

**\*\*Fees may apply for paper records as well as for postage.**

I understand that:

- Medical record information subject to this request may include records relating to mental health care, communicable diseases, HIV/AIDS test results and related information, Sexually Transmitted Infections/Sexually Transmitted Diseases, genetic screening test results, and/or treatment of substance use disorder treatment records.
- Information delivered through email is inherently unsecure unless it is encrypted. Requesting that my records be sent in an unsecure manner has inherent risk and there is risk that my health information may be intercepted and/or viewed by unauthorized persons. Bournewood Health Systems is not responsible for a third party's unauthorized access to my personal health information delivered in this format in response to my request.

Patient/Authorized Representative Signature\* \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Authorized Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

\*If signed by a patient-authorized representative, supporting legal documentation of authority must accompany this form.