Berwick
Hospital Center

Patient information (Please Print}

First Name:	Middle Initial:	Last Name:

Name at Time of Treatment (if different than above):

Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

I am requesting my records from:

Facility Name: **Address:** **City/State Zip:**	**Facility E-mail:** **Facility Fax:**

What records do you want to receive or have disclosed to the recipient noted? (Check appropriate boxes below):

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

☐ Progress Notes ☐ Emergency Room Record ☐ Discharge Summary ☐ History and Physical
☐ Consultation(s) ☐ Lab Reports ☐ Pathology Report ☐ Operative Note(s) ☐ Imaging/X-Ray Films
☐ Imaging/X-Ray Reports ☐ Entire Record ☐ Fetal Heart Monitor Strips
☐ Other (specify) _____

_____

If it exists, the following Sensitive Information can be disclosed:

☐ Alcohol Abuse ☐ Drug Abuse ☐ Communicable diseases, including HIV status
☐ Genetic Testing ☐ Psychiatric/Behavioral Diagnoses

How would you like your records delivered?

☐ Email (I understand that there is a risk to me when my information is transmitted via an unsecured e-mail system, and the information could be accessed by a third party during the transmission process. By checking the box to request Email delivery I accept this risk.)
☐ USB or CD
☐ Password Protected ☐ Not Password Protected
☐ Mail to address below ☐ I will pick up in person

If mailing, where do you want the information sent? (Fill in boxes below):

Please provide my records to: ☐ Myself ☐ Personal Representative (indicated below) ☐ Other Third Party (indicated below)

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (if applicable):

Please print your name and sign below:

Name of Patient or Personal Representative (please print)	**Relationship (please print)**

Patient's Signature or Legal Representative	Date/Time

This Healthcare Facility recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.

Patient Request for Health Information HIM-1406 Page! of 1 04/18 (Rev. 08/18, 01/20, 02/20, 06/21)	Patient Label