Patient Name_____

MR # _____

or Patient Sticker Only

EXCELA HEALTH/EXCELA HEALTH MEDICAL GROUP

Patient (Individual) Access Request

☐ FRICK HOSPITAL
☐ LATROBE HOSPITAL
☐ WESTMORELAND HOSPITAL
☐ LAUREL SURGICAL CENTER
☐ NORWIN MEDICAL COMMONS
☐ EHMG/OTHER _____

Patient Name: _____ Date of Birth: _____/_____/ _____
Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____ Phone: _____

_____ **Request for copies of Record** _____ **Access to view Record electronically**

☐ **Currently employed by Excela Health**

Entity to Release the Records:
☐ **Westmoreland Hospital** ☐ **Latrobe Hospital** ☐ **Frick Hospital**
☐ **EHMG Office:** _____ ☐ **Other:** _____

I_____**authorize the entity selected above to disclose health information**
(Patient Name)
as described below regarding my treatment, hospitalization, and/or care for my condition, which may include psychiatric impairment, drug abuse and/or alcoholism, sickle cell anemia, sexually transmitted disease or Acquired Immunodeficiency Syndrome (AIDS) or tests for or infection with Human Immunodeficiency Virus (HIV) to:

Recipient Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax (Healthcare provider only):_____

I authorize the following information to be released from my medical record:
Date(s) of service: _____
Hospital (check): ☐ Entire Record ☐ Discharge Summary ☐ History & Physical ☐ Consultation
☐ Operative Report ☐ Pathology Report ☐ Lab Results ☐ Diagnostic Testing (specify) _____
☐ Radiology Report ☐ Film/Image ☐ Emergency Dept. Report ☐ Other (specify) _____
_____
Physician Office (check):
☐ Office Notes ☐ Consultation ☐ Health Maintenance ☐ History ☐ Lab Results ☐ Radiology Results
☐ Other (specify) _____

Disclosure Format - Select only one (Paper is default if not marked):
☐ Email (a secure format) _____
☐ US Mail – paper format ☐ CD/Flash Drive (secure format) ☐ Fax (healthcare provider only)

I understand that the information being disclosed/accessed is only for the dates of service specified on this form and cannot be valid for any dates that occur after the form has been signed.

_____ _____
Signature of Patient or Legal Representative Date/Time
If signed by Legal Representative, Relationship to Patient: _____

VERBAL AUTHORIZATION (for persons physically unable to sign)
Not applicable to HIV or Drug & Alcohol Treatment Information. I witness that the patient understood the nature of this release and freely gave their oral authorization. (2 witnesses required)

Witness #1_____ Date/Time _____
Witness #2_____ Date/Time _____

☐ Patient Identification Verified

7680020

Printed Name of Employee Fulfilling Request: _____
Title:_____