

## Hillcrest Medical \_\_\_\_\_

Utica Park Clinic

**Bailey Medical Center** 

(indicate location)

(indicate location)

**Oklahoma Heart Institute** 

□ Tulsa Spine and Specialty

PATIENT INFORMATION (PLEASE PRINT)							
Patient Name							
Address							
City/State/Zip							
Date of Birth	/	/		Phone #			

	WHAT RECORDS DO YOU WANT?							
1	I understand that this information may include information relating to: AIDS, HIV, diagnosis/treatment of drug or alcohol abuse; mental, behavioral							
	health, or psychiatric care.							
	Summary (doctor notes, emergency room record, test results, operations)					Laboratory Reports		
	Discharge Summary		Emergency Room Record		Radiology Reports	□ Other		
	History/Physical		Operative Report(s)		Radiology Images			
Da	te(s) of Service:							

HOW WOULD YOU LIKE YOUR RECORDS DELIVERED?						
□ Paper:	□ I will pick up in-person	□ Mail To Home (address below)				
$\Box$ CD:	□ I will pick up in-person	□ Mail To Home (address below)				
□ Email:	I will pick up in-person I will no from (address below)   I would like my copy sent to me electronically via e-mail using the following e-mail address:   wWARNING: I understand there is a level of risk that my PHI could be read or otherwise accessed by a third party while in transit and agree to receiving my PHI by unencrypted e-mail using the e-mail address above. My signature indicates I understand and accept the risk.					
	(Signature of patient)					
1						

WHERE DO YOU WANT YOUR RECORDS SENT?					
Hillcrest Health System should provide my records 🛛 Myself		□ My Personal Representative (indicated below):			
to:					
Recipient Name		Recipient Telephone #			
Recipient Street Address	Recipient City, State Zip				
Hillowest Hospital / Uting Davk Cliv	ie veeegnizer a patient's vight under HID	14 to access conject of his/how health information. There may			

Hillcrest Hospital / Utica Park Clinic 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.

Signature of Patient/Authorized Represent	ntative	Date		
Printed Name of Patient or Legal Guardi	an	Relationship to patient, if other than self (attach appropriate legal documents)		
Please Return Completed Form to:	HIM Department 1120 S Utica Ave Tulsa, OK 74104 Fax 918-550-6576	For questions about completing this for please call 918-579-2100	rm	
For Hospital Staff use: MR/Acct #:ID V	erified:			
Processed by:	_ on	via		