Bothwell™
Regional Health Center

# Patient Request for Health Information

**Patient Information (please print)**

| | | | |
|---|---|---|---|
| First Name | MI | Last Name | |
| Name at time of treatment (if different than above) | | | |
| Date of birth (MM/DD/YYYY) | Phone | Email (optional) | |
| Street address | City | State | Zip |

**What records do you want (check below)**

| | | | |
|---|---|---|---|
| Date(s) of service _____/ _____/_____ through _____/ _____/_____ | | | |
| ❑ Emergency Room Records | ❑ Discharge Summary | ❑ History & Physical | ❑ Operative/Procedure Reports |
| ❑ Clinic Visit | ❑ Test results (Xrays, Lab/Pathology results) please specify | | |
| ❑ Inpatient or outpatient summary/abstract | ❑ Billing Records | | |
| ❑ Other (immunization records, medications lists, therapy records) please specify | | | |

**How would you like your records delivered?**

| | | |
|---|---|---|
| Paper | ❑ Home Delivery | ❑ In-person Pickup |
| Electronic Format (please specify) | ❑ Email ❑ CD ❑ Portal | ❑ Other (please specify) |
| ❑ Inspect PHI only | | |
| ***Unencrypted email poses a risk that the contents could be read by a third party. Enter email address below**** | | |
| ***BRHC does not assume liability for documents that are not encrypted to an email address provided by the requester.*** | | |
| I wish to receive documents that are | ❑ NOT encrypted | Initials |
| I wish to receive documents that are | ❑ Encrypted Secured Documents | Initials |

**Where do you want the information sent?**

| | | |
|---|---|---|
| BRHC should provide my records to | ❑ Self | ❑ Personal Representative (indicated below) |
| Recipient Name | | Recipient Phone |
| Recipient Mailing address | | Recipient email (if applicable) |

**Please print your name and sign and date below**

| | |
|---|---|
| Name of patient or personal representative (please print) | Relationship (please print) |
| Signature of patient or personal representative | Date/time |

Please return complete form to: Bothwell Regional Health Center, 601 East 14th Street, Sedalia MO 65301; email privacy@brhc.org; Fax 660-827-6804

**Bothwell Regional Health Center 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 request records.**

We will respond to your request **no later than 30 days after receipt** of request.