GRAND LAKE™ HEALTH SYSTEM
200 St. Clair Street
St. Marys, Ohio 45885
(419) 394-3335

PATIENT REQUEST FOR ACCESS TO HEALTH INFORMATION

GLHS recognizes a patient's right of access under HIPAA.

Patient Name: _____ Patient Date of Birth: _____

1. Request access for Dates of Service:_____
   OR ☐ Any and All Past, Present and Future information (until revoked in writing)

2. Information to be accessed or released: (check ONLY ONE box below)
   ☐ ALL Grand Lake Health System Records: Joint Township District Memorial Hospital (JTDMH) and all Physician Practice records
   ☐ Joint Township District Memorial Hospital records ONLY (this includes ER, Inpatient, Urgent Care, Outpatient testing, Outpatient Services, Rehab/Therapy, Outpatient Clinics (Pain/Sleep/IV, etc)
   ☐ ONLY specific portions of the JTMDH record:
   - ☐ Discharge Summary
   - ☐ History & Physical
   - ☐ Consultation
   - ☐ Operative Report
   - ☐ Discharge Instruction Sheet
   - ☐ ER Chart
   - ☐ Urgent Care Chart
   - ☐ Laboratory Reports
   - ☐ Medical Imaging Reports/CD Images
   - ☐ EKG
   - ☐ Physician Orders
   - ☐ Progress Notes
   - ☐ All Dictated Reports
   - ☐ Other (specify): _____

   ☐ ALL Grand Lake Physician Practice Records (ALL Offices, including family practice and specialty)
   ☐ ONLY records from specificPhysician Practice Office; Office Name:_____

3. Requestor: (check one)☐ Self (Patient) ☐ Patient Representative; Name _____
   IF Patient Representative, check one below AND validate parent OR documents
   ☐Parent/Guardian ☐HPOA ☐Executor of Estate ☐Other: _____

4. How would you like record copies delivered? (check all that apply)
   ☐ Paper Copy ☐ Electronic Copy via USB/Flash Drive (ONLY on device supplied by GLHS)
   - ☐ In-Person Pickup (self)
   - ☐ Allow someone else to pick up my records; Name: _____
   - ☐ Mail Delivery; Street Address: _____
     City/State/Zip: _____

   ☐ Email Copy; email address: _____ * NOTE: EMAIL is NOT a secure method of sending medical information. I understand I am requesting my information to be sent in a non-secure method. _____ (patient initials)

   ☐ Fax copies to Patient (Note: Confirm with patient that their fax machine is in a secure location) (GLHS is not responsible for unauthorized disclosure as a result of an unsecured patient fax machine). Patient Initials _____

   ☐ Release Lab Results over the phone. Please provide a password _____ (GLHS is not responsible for unauthorized disclosure as a result of someone other than the patient calling to receive Lab Results over the phone with above identified password). Patient Initials _____

_____ _____
Signature of Patient or Representative Date

For Internal use only:

Patient MRN #:	*Patient Visit #:*	
Date Requested:	*Date Completed:*	*Completed By:*