MEADVILLE MEDICAL CENTER MORE THAN A HOSPITAL

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AUTHRELEASEPHI

Patient Request for Health information

Meadville Medical Center

Form # 60075 (1/18)
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Patient Information (Please print):

First Name:	Middle Initial:	Last Name:	
Name at time of treatment (if different from above).			
Date of Birth: (MM/DD/YYYY)	Phone:	E-mail address (optional):	
Street address:	City:	State:	Zip:

1. What records do you want? (Check appropriate boxes below):
Specify location of treatment: _____
Dates of service: _____/_____/_____ _____/_____/_____
_____/_____/_____ _____/_____/_____

□ Discharge Summary □ Emergency Room Records □ Operative /Procedure Reports □ Billing records
□ Test Results (X-Rays, Lab/Pathology Results) Please specify: _____
□ Other (Immunization Records, Medical Lists) Please specify: _____

2. How would you like your records produced?:
□ Paper
□ Electronic (Email, USB, CD, Portal, Other) Please specify: _____
If delivery by unencrypted e-mail is desired, sender will not be responsible for any breach of protected health information occurring during the electronic transmission of the patient information.

3. Where would you like the information sent?:
□ Mail delivery to patient or personal representative
□ In-person pickup by patient or personal representative
□ Electronic delivery to patient or personal representative Please specify: _____

Personal Representative information (indicate below):

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

4. Please print your name and sign below:

Name of patient or personal representative (please print).	Relationship (please print):
Signature of patient or personal representative :	Date/time:

For Office use only:
Patient Verification:
□ Photo ID
□ Other: _____