UAB MEDICINE

Patient Request for Own Medical Records

UAB Medicine recognizes a patient's right to access their own protected health information.

Patient Information (please print)

Patient Name: _____ Patient Birthdate: _____ /_____ /_____

Patient Street/Mailing Address: _____

City, State, and Zip: _____ Patient Phone: _____

UAB Medicine should provide records to ☐ me for my personal use or to ☐ the party indicated below:

Name of person/organization receiving my information: _____

Street address: _____ City: _____ State: ____ Zip: _____

Are you requesting psychiatric or substance use records to be included in the release? ☐ Yes ☐ No

Date range for records: From _____ to _____ OR specific date: _____

(**If no date is listed, records for the past 12 months will be provided.)**

☐ **If your records are going to another provider, please check here and they will be provided with the continuity of care/treatment package.** (Includes key clinical notes, medication list, and histories)

Select the record package that best meets your need for this request:

☐ Package 1 - Key Clinical Notes: Current history and physical, discharge summary, operative reports, outpatient clinic notes, Emergency Department provider documentation

☐ Package 2 - Clinical Notes: Package 1 plus medication list

☐ Package 3 – Clinical Notes II: Packages 1 and 2 plus diagnostic reports and laboratory test results

☐ Package 4 – Laboratory test results, Radiology reports, and other diagnostic reports

☐ Package 5 - Entire Medical Record: Package 3 plus nursing documentation. Excludes Fetal Monitoring strips- if needed, please select below.

If you selected Package 1, 2, 3, 4, or 5 above, the following documentation, except billing records, fetal monitoring strips, and Radiology images, will be included in your selected package. However, if your request is specifically for any of the following only, please check the appropriate box(es):

☐ Operative/Procedure Report(s) ☐ Emergency Department Documentation

☐ Discharge Summary ☐ Outpatient Clinic Notes ☐ Billing Records ☐ Medication List

☐ Fetal Monitoring Strips

☐ Radiology Images: Please specify images needed: _____

☐ Other specific record needed: _____

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Records Delivery (select one)

☐ **Paper**:

- ☐ Mailed to address on this Authorization.
- ☐ Pick up by _____

☐ **Electronic:**

- ☐ Faxed to number: _____
- ☐ CD (mailed only to address on this Authorization)
- ☐ Email to address: _____

NOTICE: If I request records in electronic form, I understand that the records will be encrypted to help protect my privacy and the security of my health records and that I will be furnished with the information on how to access those encrypted records. UAB Medicine is not responsible for the privacy and security of the electronic records on the CD or in an email once they are received by the intended recipient.

I hereby request/authorize the use or disclosure of my protected health information ("PHI") as described above. This request includes any information relating to drug, alcohol use/treatment, communications with psychiatrists or psychologists, and records pertaining to sexually transmitted diseases, if they are a part of my medical record.

Once this information has been disclosed, it may be subject to re-disclosure and no longer protected by federal regulations.

Signature of patient or personal representative: _____

Printed name of patient: _____

Printed name of personal representative: _____

Relationship to the patient: _____ Date: _____

Return Completed Form:
UAB Health Information Management
Release of Information Office
1201 11th Ave. South
Birmingham, AL 35205
Fax: 205-930-6721