SUMMIT MEDICAL CENTER

FAX BACK TO 405-359-9183

ACCESS TO COPIES OF YOUR MEDICAL RECORD

Please read the following: <u>Copy of valid ID must be with request.</u>

- All requests for copies of medical records must be in writing.
- If the requester is not the patient, copies of supporting documents allowing access to the requested health records must be available and identification will be verified.
- Summit Medical Center shall not be held liable to the patient or any other person for any consequences which result from disclosure of patient records.
- The healthcare provider may prepare a summary in lieu of allowing access to or copying of the entire record.
- If the patient was discharged within the last 10 days, the record shall be made available within 30 days from date of request. (This it to allow the physician time to complete the record.)
- Reasonable clerical costs shall be applied for making the records available such as locating, screening and copying. Clerical fees are $__0___ plus _0____¢ per page for copying. Postage fees are additional.

I hereby consent to the release of any and all records containing Alcohol / Drug Abuse / HIV / Psychiatric Diagnoses under the same consideration as above. I understand that such information can not be released without my specific consent, except under a Court Order.

Patient's Name:_____ Date of Birth: _____
(Print)

Address: _____

City/State/Zip: _____ Phone: _____

Dates of Service Needed: _____

Specific Portions Only (List): _____

<u>Please complete if you want records emailed:</u>

I understand the security of email cannot be guaranteed and that unauthorized individuals may be able to access the message. I understand the information sent via electronic communication may include information that may indicate the presence of a communicable disease or non-communicable disease, mental health records or substance use disorder records. It is my responsibility to notify Summit Medical Center if the email address information changes after submitting this form. **I understand and agree to the statements above and wish to have my records sent to the Recipient via email at:**

_____ @ _____

Signature: _____ Date: _____

Witness: _____ Date:

Records physically handed to patient on Date: _____