Patient Request for Health Information

Patient Information (Please Print):

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Home Phone:	Mobile Phone:	
Street Address:	City:	State:	Zip:

What records do you want? (Check appropriate boxes below):

Date(s) of Service: ____/____/____ through ____/____/____ Facility/Clinic Name:________________________________

□ Discharge Summary(s)
□ Emergency Room Record(s)
□ Operative/Procedure(s)
□ Consultation(s)
□ Billing Record(s)

□ Test Results (X-Rays,
□ Lab/Pathology Results) Please specify: ________________
____

□ X-ray digital media
□ Other: ______________________
____
□ Substance Use Disorder Treatment Records

Who will be getting this information from Intermountain Healthcare? (Check one):
□ Myself, the patient □ Personal Representative (Name/Relationship: ______________________________________)

What type of copies do you want? (Check one):
□ Paper copies □ Electronic Copies/DVD

How would you like your records delivered? (Check appropriate boxes below):
□ Physical Delivery (Please specify delivery method):
- □ Mail to my street address listed above
- □ In-person pickup by me (Please bring photo ID)
- □ Mail to or pick up by my Personal Representative listed above – please specify address and phone:
____ (Please bring photo ID for pickup)
- □ Mail to me at a different location, please specify address:
____

□ Electronic Delivery (Please specify delivery method):
- □ Home or Work Email. Please specify: ____
(*Please understand that home or work email addresses are not necessarily secure. Information can possibly be read by employer if a work email, by hackers as it is transmitted insecurely over the Internet, or by family upon delivery to a home computer. By checking this option, you agree to take these risks*.)
- □ Other, please specify: ____

Note: There may be charges associated with processing a request and producing requested records.

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**

RETURN COMPLETED FORM TO: Address: P.O. Box 571069, Murray, UT 84157; Email: medrecreq@r1rcm.com or Fax: 385-215-7047

***NOT PART OF THE MEDICAL RECORD**

NCID: 529830275 08/2023 © IHC Health Services, Inc. (2020)