Advocate Health Care | Aurora Health Care

Patient Request for Health Information

Did you know you can request and access your medical records online through your patient portal? Visit: https://livewell.aah.org.

(One Patient Per Form)

Patient Name: _____ Date of Birth: _____

Street Address: _____ City, State, Zip: _____

Telephone: _____ Email: _____

Treatment Facility/Physician: _____

Treatment Dates: _____

Information Requested (select all that apply):

Medical Records

☐ Facility Summary (Includes all items in **bold**)

☐ **Discharge Summary**
☐ **History & Physical**
☐ **Consultation Reports**
☐ **Office/Progress Notes**
☐ **Emergency Record**
☐ **Operative Reports**
☐ **Laboratory Reports**
☐ **Pathology Reports**
☐ **Radiology Reports**
☐ **Immunizations**
☐ Sleep Study Reports
☐ Entire Medical Record
☐ Other _____

Imaging (requires CD format)

☐ Radiology Images (X-Ray/CT/MRI/US)
☐ Cardiology Images (Echo/Cath Lab)
☐ Neurology Images (EEGs)
☐ Fetal Ultrasound Images
☐ Other Imaging: _____

Billing

☐ Itemized Bill(s)
☐ UB04 Form
☐ CMS 1500 Form
☐ Other Billing: _____

Send my requested information to:

☐ Myself

☐ Other: _____ _____
Name of Facility, Person, Company — Street Address or PO Box, City, State, Zip Code

_____ _____ _____
Phone Number — Fax Number — Email Address

Requested Formt/Delivery Method: ***(Fees may apply)***

By Mail:
☐ Paper Copy
☐ CD

Electronically:
☐ Encrypted Email
☐ Patient Portal

Other:
☐ In Person Pick-up at: _____
☐ Paper ☐ CD

I understand the information to be disclosed may include information regarding genetic testing, genetic services and family medical history, mental health/developmental disabilities, Substance Use Disorder, HIV Test results and AIDS/AIDS-related illness.

_____ _____ _____ _____
Date — Time — Patient or Legal Representative Signature — Relationship to Patient

_____
Print Name

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign. Supporting documentation may be required.

Minor Authorization: If a minor consented to treatment by a licensed physician for pregnancy, sexually transmitted diseases, outpatient behavioral or mental health care, or outpatient treatment for controlled substances or alcohol without parental consent, the minor may sign this authorization. If the minor is receiving substance use disorder treatment with parental or guardian consent, both the minor and the parent or guardian may sign this authorization.

_____ _____ _____
Date — Time — Signature of Minor

_____
Print Name