

# Barnes-Jewish Hospital

**BJC** HealthCare

Mail Stop: 90-59-341  
One Barnes-Jewish Hospital Plaza • St. Louis, MO 63110

**Phone: 314-362-3935 FAX: 314-747-7211**

## **REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION BY INDIVIDUAL PATIENTS**

Individual (Patient) Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_ Social Security # (or last 4 digits) \_\_\_\_\_

Patient Address: \_\_\_\_\_

Telephone Number: (Home) (\_\_\_\_\_) \_\_\_\_\_ (Cell) (\_\_\_\_\_) \_\_\_\_\_

***I request only the following information to be released:***

- |  |   |
|--|---|
| <input type="checkbox"/> Abstract (includes all * documents) | <input type="checkbox"/> X-Ray Report*              |
| <input type="checkbox"/> Emergency Report*                   | <input type="checkbox"/> Mammogram Report*          |
| <input type="checkbox"/> Discharge Summary*                  | <input type="checkbox"/> Cardiac Cath Lab Reports*  |
| <input type="checkbox"/> History & Physical*                 | <input type="checkbox"/> EKG                        |
| <input type="checkbox"/> Progress Notes*                     | <input type="checkbox"/> Medication Report          |
| <input type="checkbox"/> Consults*                           | <input type="checkbox"/> Advanced Directive         |
| <input type="checkbox"/> Operative Report*                   | <input type="checkbox"/> Expiration Documents       |
| <input type="checkbox"/> Pathology Report*                   | <b>Films</b>  |
| <input type="checkbox"/> Laboratory* (specify) _____         | <input type="checkbox"/> X-Ray Films                |
| <input type="checkbox"/> Itemized Billing Statement          | <input type="checkbox"/> Cardiac Cath Lab Cine Film |
| <input type="checkbox"/> Good Faith Estimate                 | <input type="checkbox"/> Mammogram Film             |
| <input type="checkbox"/> Other (specify) _____               |   |

Date(s) of Treatment: \_\_\_\_\_

Would you like your records to be mailed to the above address:  Yes  No

To another address as indicated below:  Yes  No

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Would you like records sent electronically (if possible) to yourself or a designated individual?  Yes  No

To whom? \_\_\_\_\_ Email address: \_\_\_\_\_

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Signature of Individual or Personal Representative

Date

**Processing Your Requested Information:**

You may be charged a fee for the copying of requested health information. This fee will be based on the cost of the labor and supplies involved in copying the requested health information and the postage for mailing the copies to you. If you do not want the requested records mailed, you may contact our office after 30 days to pick-up your records. Response to your request for health information will be within 30 days of receipt of your request. If we require additional time to respond to your request, we will contact you to inform you of this extension of time.

We appreciate your patience while we process your request.