Patient Request to Access Health Information

Name (please print): ____

Name at Time of Treatment (if different than above): ____

Address: ____

Phone: _______________________________________ **Email** (optional)___________________________

Date of Birth: __________________________________

1. **Dates of Service:** ______________________through __________________________

2. **What records do you request?** (Check appropriate boxes)

- ☐ Discharge Summary
- ☐ Operation/Procedure Reports
- ☐ Test Results (Radiology, Lab, Pathology) Please specify_____________________
- ☐ Emergency Room Records
- ☐ Billing Records
- ☐ Other (Immunization Records, Medication Lists) Please specify __________________

3. **Please state how you would like to inspect or review your health information.**

- ☐ Scheduled time by calling (228) 865-3172
- ☐ Paper Please specify: In-Person Pickup____
- ☐ Electronic Please specify: ____
- ☐ Mailed to address above.

3. **Print Name** (*or Legal Representative*): ____

4. **Signature** (*or Legal Representative*): ____

5. **Legal Representative's relationship to patient**: __________________________________

6. **Date**: ______________________________

7. **Please Return Completed Form to**: Memorial Hospital at Gulfport
Health Information Management
P.O. Box 1810
Gulfport, MS 39502-1810
Phone: (228) 865-3172
Fax: (228) 865-3557

Memorial Hospital at Gulfport recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges with processing a request and producing requested records.