CommonSpirit

Patient Access Request to Their Protected Health Information

This form is for patient requests to access (view), receive or send copies of **their own medical information.**

To verify your identity and provide the correct information, please complete the below:

Patient Name ____ Date of Birth ________________________

Patient Previous/Other Name(s):____

Email Address:____

Address ____ Phone number________________________

City _______________________________________ State_________________________ Zip________________

Facilities or locations from which you are requesting records. Please list or check as appropriate:

☐ ST.VINCENT INFIRMARY *(2 St. Vincent Circle, Little Rock, AR 72205)*

☐ ST.VINCENT NORTH *(2215 Wildwood Ave, Sherwood, AR 72120)*

☐ ST.VINCENT MORRILTON *(4 Hospital Drive, Morrilton, AR 72110)*

Dates of Service (please list date or date range for records requested)

From _____________________ To __________________________

Parts of the record requested:

(Below are the most frequently requested documents. This does not constitute your entire medical record, which you have the right to request.*)

Check (✓) all that apply:

__ Abstract (Includes[1])

__ Discharge Summary /Final Diagnosis[1]

__ History and Physical Records[1]

__ Consultation Reports[1]

__ Operations and Procedures[1]

__ Results of Diagnostic Testing[1]

__ Emergency Room Records

__ Lab Reports

__ Radiology (for example: X-Ray) Reports

__ Other Diagnostic Reports

__ Diagnostic Images (Prepped by Radiology Dept)

__ Immunization (shot) Record

__ Physical Therapy Notes

__ Physician Notes

__ Medication List

__ Itemized Bill

__ Other*: ____

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☐ Infirmary
2 St. Vincent Circle • LR, AR 72205

☐ North
2215 Wildwood Ave. • Sherwood, AR 72120

☐ Morrilton
4 Hospital Drive • Morrilton, AR 72110

☐ Hot Springs
300 Werner Street • Hot Springs, AR 71913

PATIENT BARCODE

I request the form of release of information be:
____ Electronic (HIM Department Portal) *email address required: ____

_______ Paper (U.S. Mail or pick up) ____ Other (USB, etc...**)________________________________
**Device must be provided by the facility

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

I will pick up the records (check here) _________
(or)
Please send the records to the person or party(ies) below at the address provided:

Recipient Name:____

Address for receipt of record:
____
____
____
____

Email Address for receipt of records:
____

I understand there may be a minimal fee charged for the records.

Signature of Patient or Guardian

____ Date___________________________

Print name ____

If you are the Personal Representative of the Patient:
Signature of Personal Representative____

Authority or relationship to patient ____

(Please include copies of any documents that establish Personal Representation such as Power of Attorney document, Guardianship papers, Executor of Estate or Administrator of will documents.)