



# PATIENT DIRECTED REQUEST FOR HEALTH INFORMATION

UCBC recognizes the patient's right to access to their health information/records as well as the right to direct the organization to send their health information to another designated person or entity. The patient's request to direct health information to another person must be in writing, signed, and clearly identify the designated person or entity. UCBC will accept any written request from a patient. While this form is **not** required, it may be used to simplify the process and ensure timely and accurate processing. Note that processing fees may apply.

## PATIENT INFORMATION

First Name, Middle Initial, Last Name (Previous Names)

Date of Birth

Address

Phone Number

- |  |  |
|--|--|
| <input type="checkbox"/> Billing Records                 | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Office Notes                    | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Hospitalization Summary         | <input type="checkbox"/> Lab Reports       |
| <input type="checkbox"/> Diagnostic Imaging Films/X-rays | <input type="checkbox"/> _____             |
| <input type="checkbox"/> Chemotherapy Treatment          | <input type="checkbox"/> _____             |

Dates of Service: \_\_\_\_\_

## RECIPIENT INFORMATION

I am directing UCBC to disclose my health information/records to:  PATIENT/SELF  3<sup>RD</sup> PARTY INDICATED BELOW

Name & Address of Individual or Entity Directed to Receive Information

## DELIVERY METHOD REQUESTED

- Us Mail To: \_\_\_\_\_
- E-Mail To: \_\_\_\_\_  
*Delivery by unencrypted/ unsecured e-mail could lead to unauthorized access by third party; patient accepts risk.*
- Pick-up at UCBC Location:  Athens  Monroe  Winder  Toccoa  Lavonia  Covington  Greensboro
- Other: \_\_\_\_\_

## FORMAT REQUESTED

- Paper  Encrypted CD  E-Mail  Other: \_\_\_\_\_

**X**

Signature of Patient/Personal Representative

Date Signed

Date Received:

Date Processed:

Processed By: