Health Information Management
Release of Information
2601 E. Roosevelt St.
Phoenix, AZ 85008
ROI@valleywisehealth.org
Phone: 602-344-5266 | Fax: 602-344-5092

PATIENT REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Please check (✓) the appropriate box(es) (❑) and fill in the blank(s) as needed.

Individual/Patient Name (Last, First): _____

Patient's Date of Birth: _____ SSN: _____

Phone Number: (____) _____ Medical Record Number: _____

Individual/Patient Address: _____

Please Check Specific Information Requested: (for information related to AIDS/HIV, Communicable Diseases, Behavioral Health, Alcohol/Drug Abuse or Genetic Testing a separate Authorization is required, see Valleywise Health form 43439)

- ❑ All Records
- ❑ Abstract of record **(Provider Notes, Procedures, & Test Results Only)**
- ❑ Discharge Summary
- ❑ Face Sheet
- ❑ History & Physical
- ❑ Images
- ❑ Laboratory Reports
- ❑ Medication Records
- ❑ Nursing Assessments/Notes
- ❑ Pathology Reports
- ❑ Operative Report
- ❑ Operative Notes
- ❑ Other Procedure Report
- ❑ Radiology Reports
- ❑ Itemized Billing Statement (Paper Copy Only)
- ❑ Progress Notes (specify) _____
- ❑ Other (specify) _____

Date(s) of Treatment: ❑ Specific Date(s): _____thru _____ or ❑ All Date(s) of Treatment

In what format would you like to receive your records: (select one of the following)
❑ Valleywise Health Patient Portal (MyChart) ❑ Paper Copy ❑ Electronic Copy: ❑ CD ❑ USB ❑ E-Mail (as listed below)

Release or Mail To:

Individual/Legal Guardian/Personal Representative: _____

Street Address: _____

City, State and Zip Code: _____

Phone Number of Individual Receiving Records if not Patient: ( )_____

Fax Number of Individual Receiving Records if known: ( ) _____

Email Address: _____

Email is not a secure means of communication. We will encrypt email communications containing your records unless you tell us you prefer Valleywise Health to use unencrypted email. If you prefer we not encrypt our communications to you, your initials permit Valleywise Health to email your requested information unencrypted. However, if a file size limitation exists an alternate format to receive your records will be required. Initial Here: _____

Processing Your Requested Information:

Valleywise Health may charge a fee for the copying of requested health information plus postage for mailing the copies to you. If you would like a copy of your record to be provided on portable media such as a CD or USB drive, we may charge you the actual cost of the portable media.

Valleywise Health will respond to your request for health information within 30 days of our receipt of your request. If, however, your health information is not readily accessible by Valleywise Health or is maintained in an off-site storage location, Valleywise Health has an additional 30 days to respond to 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.

_____

Signature of Patient/Legal Guardian/Personal Representative Date