



- Hillcrest Medical \_\_\_\_\_ (indicate location)
- Bailey Medical Center
- Utica Park Clinic \_\_\_\_\_ (indicate location)
- Oklahoma Heart Institute
- Tulsa Spine and Specialty

**PATIENT INFORMATION (PLEASE PRINT)**

<b>Patient Name</b>			
<b>Address</b>			
<b>City/State/Zip</b>			
<b>Date of Birth</b>	/	/	<b>Phone #</b>

**WHAT RECORDS DO YOU WANT?**

*I understand that this information may include information relating to: AIDS, HIV, diagnosis/treatment of drug or alcohol abuse; mental, behavioral health, or psychiatric care.*

- |  |   |
|--|---|
| <input type="checkbox"/> Summary (doctor notes, emergency room record, test results, operations)                                     | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Room Record <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Other              |
| <input type="checkbox"/> History/Physical <input type="checkbox"/> Operative Report(s) <input type="checkbox"/> Radiology Images     |   |

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

**HOW WOULD YOU LIKE YOUR RECORDS DELIVERED?**

<input type="checkbox"/> Paper:	<input type="checkbox"/> I will pick up in-person	<input type="checkbox"/> Mail To Home (address below)
<input type="checkbox"/> CD:	<input type="checkbox"/> I will pick up in-person	<input type="checkbox"/> Mail To Home (address below)
<input type="checkbox"/> Email:	I would like my copy sent to me electronically via e-mail using the following e-mail address: _____ <b>WARNING: I understand there is a level of risk that my PHI could be read or otherwise accessed by a third party while in transit and agree to receiving my PHI by unencrypted e-mail using the e-mail address above. My signature indicates I understand and accept the risk.</b> <p align="right"><b>(Signature of patient)</b></p>	

**WHERE DO YOU WANT YOUR RECORDS SENT?**

Hillcrest Health System should provide my records <input type="checkbox"/> Myself <input type="checkbox"/> My Personal Representative (indicated below):		
to:		
Recipient Name	Recipient Telephone #	
Recipient Street Address	Recipient City, State Zip	

*Hillcrest Hospital / Utica Park Clinic recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.*

\_\_\_\_\_  
Signature of Patient/Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to patient, if other than self  
(attach appropriate legal documents)

**Please Return Completed Form to:**     **HIM Department**  
1120 S Utica Ave  
Tulsa, OK 74104  
Fax 918-550-6576

For questions about completing this form  
please call 918-579-2100

**For Hospital Staff use:**  
MR/Acct #: \_\_\_\_\_ ID Verified: \_\_\_\_\_

Processed by: \_\_\_\_\_ on \_\_\_\_\_ via \_\_\_\_\_  
Notes: \_\_\_\_\_