PATIENT ACCESS REQUEST FORM

******Please Note: Charges MAY apply******

******Failure to remit payment of invoice may result in submission to a collection agency******

Patient Name: ___________________________
Address: ___________________________
Address: ___________________________
Date of Birth: ___________________________
Patient Phone Number: ___________________________
Medical Record #: (if known) ___________________________

I am requesting a copy of my medical information from Geisinger:
☐ All Sites ☐ Specific Clinic or Hospital____.

The information requested is the time period from____________to____________("present" equals date of signature).

***Do Not use this form if you are requesting information related to any testing, diagnosis and/or treatment of the following AND you are instructing us to send information to a third party. Please instead use an Authorization to Release Medical information or a comparable form.**

- Alcohol/Substance Use Disorder
- Mental Health/Rehabilitation
- HIV/AIDS

SPECIFIC INFORMATION TO RELEASE - (Check box of items to be released)

☐ Clinic Notes
☐ Colonoscopy
☐ Consultation Report(s)
☐ Disability/FMLA Form
☐ Discharge Summary
☐ EEG, EKG, Stress Test
☐ Emergency Department Notes
☐ Endoscopy
☐ History and Physical
☐ Immunizations
☐ Itemized Bills
☐ Laboratory Reports
☐ Medications
☐ Operative Reports
☐ Pathology Reports
☐ X-Ray Films
☐ X-Ray Reports
☐ *HIV/AIDS
☐ *Alcohol/Substance Use Disorder
☐ *Mental Health/Rehabilitation

Other
____
____
____

Disclosure Format (Paper is default if not marked):

☐ MyGeisinger (pdf format)
☐ US Mail - paper format
☐ CD - secure pdf format
☐ Fax
☐ Other: please specify__

Recipient: Name:___________________________
Address of Individual or Organization: (Must be complete address) ___________________________
____
____
Phone Number if requesting to go to someone other than the patient: ___________________________
Fax Number (if applicable): ___________________________

SIGNATURES

NOTE: IF PATIENT IS UNDER 14 YEARS OF AGE AND IS NOT EMANCIPATED MINOR THE PARENT OR GUARDIAN MUST SIGN. IF BETWEEN THE AGES OF 14-18 YEARS OF AGE, BOTH SIGNATURES ARE NEEDED.

Date/Time:______________**Patient Signature**:___________________________

If patient is unable to sign authorization form because of physical condition or age, complete the following:
Patient is a minor or patient is unable to sign authorization because:___________________________

Date/Time:______________**Signature**:______________________**Relationship**: ______________
(Parent/legal or personal representative with authority under State law to make health care decisions for the patient)

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