Benefis HOSPITALS

For office use only

_____ _____

**MEDICAL RECORD NUMBER** **ACCOUNT NUMBER**

**PATIENT REQUEST FOR ACCESS TO PHI (PROTECTED HEALTH INFORMATION)**

## PLEASE COMPLETE INFORMATION BELOW

**1. Patient Information**

Legal name of Patient_____

Date of Birth and/or Social Security Number_____

**2. I request access to my medical information at Benefis Health System.**

❑ Mail Address_____

_____

Phone _____

❑ Fax Fax Number _____

❑ Email Email Address_____

❑ Electronic Media (e.g. USB Drive, CD) ❑ Electronic medical record (for employees only)

**3. This request is for** ❑ Hospital Records Only ❑ Physician Office (BMG) records only

❑ Both Physician & Hospital Records

**4. If request is for specific date(s) of service, please specify.**_____

**5. This request will expire on this date or event** _____

If no date or event is specified, this authorization will expire 12 months from date signed.

**6. Signature**

_____ _____ _____

Patient's Signature Date of Signature

Patient's Personal Representative Signature Legal Relationship to Patient* Date of Signature

**Examples of legal relationships include a parent of a child if the child is under 18 years of age or a court document showing a legal relationship. Legal relationships for this document do not ordinarily include the spouse. For questions, please contact the Benefis Medical Record Dept. at 406-455-5642*

**7. Identification of requester (for Benefis Health Systems use)**

_____ Government-issued Picture ID _____ Signature verified _____ Requester known to me _____ Government badge

**8. To validate, completed form must be returned to the Medical Record Department.**