INTEGRIS HEALTH

Patient Request for Health Information

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Home Phone:	Cell Phone (optional):	
Street Address:	City:	State:	Zip:

What records do you want? (Check appropriate boxes below):

Date(s) of Service:____/____/____through____/____/____Location (Facility/Phys Office Name):_____

☐ Pertinent Information (Includes Physician Notes and Diagnostic Results)
☐ Entire Medical Record (Excludes Psychotherapy Notes)
☐ Other (Specify Below)
☐ Discharge Summary
☐ Emergency Room Report
☐ Operative Reports

Specify: _____

INTEGRIS Health should provide my records to: ☐ Self ☐ Person/Organization Specified Below

Recipient Name:	Recipient Phone:
Recipient Mailing Address:	Recipient Fax (For Patient Care Only):

In what format would you prefer your records? (Check all that apply)

☐ Paper ☐ CD ☐ Radiology disc (for images) ☐ Portal (must choose portal as delivery method)

How would you prefer your records delivered?

☐ Mail ☐ Fax ☐ Portal (https://www.integrisandme.com) ☐ In Person Pick-Up:

☐ E-Mail (subject to file size limitations) _____ Location of Pick Up: _____

Please print your name and sign below:

Name of Patient or Personal Representative (please print)	**Relationship (please print)**
Signature of Patient or Personal Representative	**Date/Time**

Please return completed form to:

INTEGRIS HIM Department **3366 NW Expressway, Bld D Ste. C20** **Oklahoma City, OK 73112**	**Fax: (405) 552-8704** **Email: HealthInfoManagement@integrisok.com** **Questions? (877) 778-7211**

There may be charges associated with processing a request and producing requested records pursuant to 45 CFR164.524(c)(4)
My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

Patient Label
Patient Name:
MRN:
DOB: