# Patient Request for Health Information

ROI Number: ______________

HIM Initials: ______________

**Patient Information (Please Print)**

| First Name: | Middle Initial: | Last Name: | |
|---|---|---|---|
| Name at time of Treatment (If different that above): | | | |
| Date of Birth: (MM/DD/YYYY): | Phone: | Email Optional: | |
| Street Address: | City: | State: | Zip: |

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

Date(s) of Service: ____/____/____ through ____/____/____

- ☐ Discharge Summary ☐ Emergency Room Records ☐ Operative/Procedure Reports ☐ Billing Records
- ☐ Test Results (X-rays, Lab/Pathology Results) Please Specify: ______________________________
- ☐ Other (Medical lists) Please Specify: ______________________________

**How would you like your records delivered?**

- ☐ Paper
  - ☐ Home Delivery
  - ☐ In-Person Pickup
- ☐ Electronic (Email): ______________________

  Password: ______________________

**Where do you want the information sent? (Fill in boxes below):**

Wooster Community Hospital should provide my records to: ☐ Self ☐ Personal Representative (indicated below)

| Recipient Name: | Recipient Phone:<br>Recipient Fax: |
|---|---|
| Recipient Mailing Address: | Recipient E-mail (if applicable): |

**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:**

| | |
|---|---|
| | **Email:**<br>**Fax:** |
| | **Questions:** |

*Wooster Community Hospital Health System 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.*

WCH 08201 040620