WH0846HW
Issued 04/2018
No Previous Edition

PATIENT REQUEST FOR HEALTH INFORMATION

Wayne HealthCare • 835 Sweitzer Street • Greenville, Ohio 45331

Patient Information (Please Print) MR Number: _____

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

What records do you want? (Check appropriate boxes below): Date(s) of Service: _____

☐ Discharge Summary ☐ Emergency Room Records ☐ Operative/Procedure Reports ☐ Billing Records

☐ Test Results (X-Rays, Lab/Pathology Results) Please Specify: _____

☐ Other (Immunization Records, Medication Lists) Please Specify: _____

What do you need them for? _____

How would you like your records delivered?

☐ Paper

☐ Home Delivery ☐ In-Person Pickup

☐ Electronic (E-mail, CD, Other) Please Specify: _____

Where do you want the information sent?

Wayne HealthCare should provide my records to: ☐ Self ☐ Personal Representative (indicated below)

Recipient Name:	Recipient E-mail (if applicable):		
Recipient Phone:	Recipient Fax:		
Recipient Mailing Address:	Recipient Mailing City:	Recipient Mailing State:	Recipient Mailing Zip:

Please print your name and sign below:

_____ _____

Signature of Patient Date/Time

_____ _____

Designated/Personal Representative (Please Print) Relationship (Please Print)

_____ _____

Signature of Designated/Personal Representative Date/Time

Please return completed form to:

Attn: Health Information Management/ROI
Wayne HealthCare
835 Sweitzer Street
Greenville, Ohio 45331

Fax: Fax: (937)547-5738
Email: HIM@waynehealthcare.org

Wayne HealthCare *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.*