BARNES-JEWISH Hospital
BJC HealthCare

Mail Stop: 90-59-341
One Barnes-Jewish Hospital Plaza • St. Louis, MO 63110
Phone: 314-454-5934

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION BY INDIVIDUAL PATIENTS

Please check (✔) the appropriate box(es) (☐) and fill in the blank(s) as needed.

Individual Patient Name (Last, First): _____

Patient's Former Names (where applicable): _____

Patient's Date of Birth: _____ SSN: _____

Telephone Number: (Home) ( ) _____ (Work) ( ) _____

I request only the following information to be released:

- ☐ Designated Record Set (all pages of available medical record for date(s) of treatment requested)
- ☐ Emergency Report
- ☐ Discharge Summary
- ☐ Laboratory (specify): _____
- ☐ Other: _____
- ☐ History & Physical
- ☐ Operative Report
- ☐ Pathology Report
- ☐ X-Ray Reports
- ☐ X-Ray Films
- ☐ Mammograms
- ☐ Cardiac Cath Lab Reports
- ☐ Cardiac Cath Lab Cine Film
- ☐ EKG
- ☐ Clinic Records
- ☐ Pharmacy Records
- ☐ Itemized Billing Statement

Date(s) of Treatment: _____

Would you like your records to be mailed: ☐ Yes ☐ No

Release or Mail To:

Individual/Legal Guardian/Personal Representative _____

Street Address _____

City, State and Zip Code _____

Processing Your Requested Information:

Barnes-Jewish Hospital may charge a fee for the copying of requested health information. This fee will be based on the cost of the labor and supplies involved in copying the requested health information and the postage for mailing the copies to you. If you do not want the requested records mailed, you may contact our office after 30 days to pick-up your records.

Barnes-Jewish Hospital will respond to your request for health information within 30 days of our receipt of your request. If, however, your health information is not readily accessible by Barnes-Jewish Hospital or is maintained in an off-site storage location, Barnes-Jewish Hospital has 60 days to respond to your request. If we require additional time to respond to your request, we will contact you to inform you of this extension of time.

We appreciate your patience while we process your request.

_____ Date:_____ Time: _____
Signature of Patient/Legal Guardian/Personal Representative

Barnes-Jewish Hospital Use Only: **Request Date:** _____

Date Access Granted: _____

Date Access Denied: _____
(Must Complete Denial of Access Form)

DO NOT WRITE BELOW THIS LINE

BJ 3-3343-681