Completion Date:

Request for Access to Health Information

(Attachment 19)

As a patient of a University of Miami provider or hospital, you are encouraged to request and receive health information electronically using the MyUHealthChart patient portal https://myuhealthchart.com/mychart/. To request and receive records outside the patient portal, sign and submit this form.

Date of Request:_____ Medical Record Number: _____

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Last 4 Digits of SSN: _____

Email: _____ City: _____

Address: _____ Zip: _____

State: _____

Write date(s) requested here:	**Write physician name(s) requested here:**

Check box here to request medical record copies by visit type

☐ **In-Patient** ☐ **Outpatient** ☐ **Emergency** ☐ **Physician Office** ☐ **Surgery/Procedure**

☐ **All Encounters (Entire Medical Record)** ☐ ***Billing records** Authorization effective 1 year unless otherwise revoked in writing*

☐ **Radiology** ☐ **Lab** ☐ **Immunizations** ☐ Other: _____

Send my records via:

☐ **US Mail** *Records delivered via Priority mail to the address indicated.

☐ **Email** ☐ **In Person Pickup** ☐ **Other: _____**

☐ **Send records to my patient portal account. *Download required***

I understand that the information to be released may include a diagnosis or reference to the following condition(s): behavioral health service/psychiatric care, sickle cell anemia, genetic testing, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.

Effective May 1, 2020, there is no cost for copies of Uhealth medical records provided for patient requests.

_____ _____ _____ AM/PM

Signature of patient or personal representative Date Time

_____

If personal representative, authority to act on behalf of patient/ Relation to Patient

HEALTH INFORMATION MANAGEMENT

P: 305.243.5272 uchartecopy@med.miami.edu **F:305.243.5274**

REQUEST FOR ACCESS TO HEALTH INFORMATION

Form D3900018E
Revised 09/16/24

Patient Identification Sticker