Wabash General Hospital

People you know, helping people you love

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):	Phone:		Email *(optional)*:	
Street Address:	City:		State:	Zip:

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

Date(s) of Service:__________/__________/__________through__________/__________/__________

☐ Office Visits ☐ 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: ______________________________

How would you like your records delivered?

☐ Paper ☐ CD/Flash Drive

☐ Home Delivery ☐ In-Person Pickup ☐ Fax ☐ View Chart in Department

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

Wabash General Hospital should provide my records to: ☐ Self or ☐ Personal Representative *(indicated below)*

Recipient Name:	Recipient Phone/Fax:
Recipient Mailing Address:	Recipient Email *(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
Signature of Witness to Signing	Date/Time

Please return completed form to: 1418 College Drive, Mt. Carmel, IL 62863 | Fax: 618-263-6481 | Question? 618-263-6313

Wabash General Hospital recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing and producing requested records.