Patient Request for Access

Did you know you can view most of your medical record online via IQ Health? Go to www.crhealthcare.org and click on My Physicians Records. If you would like a copy of your medical record, please complete the form below.

I am a patient of Columbus Regional Health Network and my information is listed below:

Patient Name: ______________________ Date of Birth: ______________________

Street Address: ______________________ Last 4 numbers of SSN: ______________________

City, State, Zip: ______________________ Telephone: ______________________

I would like for ______________________ **to** (choose one):
(list facility or practice)

☐ **give me a copy of my health information**
☐ **send my records to:**

Advanced Urology Leland — 144 Poole Rd. Suite 102 Leland, NC 28451
(Name of Facility, Person, Company) (Street Address or PO Box, City, State, Zip Code)

910-641-8650 — 910-769-4655
(Phone Number) (Fax Number)

I would like these dates of service to be released: ______________________

I want these parts of my record:

Hospital (check all that may apply):	Office/Clinic (check all that may apply):	Behavioral Health/Sub. Abuse (check all that may apply):
☐ Hospital Summary	☐ Office/Clinic Summary	☐ Hospital/Discharge Summary
☐ Discharge Summary ☐ Emergency Record	☐ Office Visits	☐ Assessments
☐ History and Physical ☐ Operative Reports	☐ Physical Exam	☐ Progress notes
☐ Laboratory reports	☐ Laboratory Reports	☐ Medications
☐ Radiology/X-Ray Reports	☐ Radiology Reports	☐ Lab reports
☐ Other ______	☐ Other ______	☐ Other ______
☐ Entire record	☐ Entire record	☐ Entire record (Not including psychotherapy notes)
☐ Itemized Bill	☐ Itemized Bill	☐ Itemized Bill

I want these records as a (choose one):

☐ **Paper copy**
☐ **Other:** ______________________

I want you to (choose one):

☐ **Mail them**
☐ **Fax them to:** ______________________
☐ **Prepare them to be picked up by:** ______________________

As an alternative, you may schedule an appointment with your healthcare provider's office to see your record in person. Please note it may take up to 30 days to schedule the appointment or provide copies.

Signature: ______________________ **Print Name:** ______________________

Relationship to Patient: ______________________ **Date:** ______________________

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this for the patient. (Written Proof May be Requested)

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