

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 - Whiteville	320 Jefferson Street Whiteville NC 28472
(Name of Facility, Person, Company)	(Street Address or PO Box, City, State, Zip Code)
910-642-5832	910-642-8814
(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):
<input type="checkbox"/> Hospital Summary <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History and Physical <input type="checkbox"/> Laboratory reports <input type="checkbox"/> Radiology/X-Ray Reports <input type="checkbox"/> Other _____	<input type="checkbox"/> Office/Clinic Summary <input type="checkbox"/> Office Visits <input type="checkbox"/> Physical Exam <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Other _____	<input type="checkbox"/> Hospital/Discharge Summary <input type="checkbox"/> Assessments <input type="checkbox"/> Progress notes <input type="checkbox"/> Medications <input type="checkbox"/> Lab reports <input type="checkbox"/> Other _____
<input type="checkbox"/> Entire record <input type="checkbox"/> Itemized Bill	<input type="checkbox"/> Entire record <input type="checkbox"/> Itemized Bill	<input type="checkbox"/> Entire record (Not including psychotherapy notes) <input type="checkbox"/> 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)