

AURORA CHARTER OAK PATIENT REQUEST FOR ACCESS TO MEDICAL RECORDS

Patient Name _____ Date of Birth _____

I hereby request that Aurora Behavioral Health Care/Charter Oak provide access to the medical record of the above named patient.

This request is made by:

- Patient Legal conservator of the person of an adult patient*
 - Beneficiary/personal representative of a deceased patient Parent of minor Guardian of minor patient
- (attach copy of death certificate and/or beneficiary papers) (attach custody papers) (attach court papers)**

The type of access requested is: Copies of the record

If you wish to pick up medical records, please check here

If you wish to have the medical records mailed, please check here and **attach a copy of a valid picture identification**
(due to confidentiality records may not be faxed or e-mailed)

You may mail this form to Aurora Charter Oak Hospital 1161 E. Covina Blvd. Covina, CA. 91724 ATT: Medical Records Dept. or e-mail to Roxanne.temple@aurorabehavioral.com or Fax to 626-938-7013.

I REQUEST ACCESS TO: Psychiatric Evaluation/Mental Status Examination X-Ray Lab

Medical History & Physical Examination Discharge Summary Other _____

FOR THE FOLLOWING PURPOSE: Continuing care Legal proceedings Personal
 Other _____

Requestor Name; (Patient name, Guardian, Parent, etc. (print) _____

Mailing address _____ City _____ State ____ Zip Code _____

Phone # with area code _____

Relationship if other than patient _____

Date: _____ Time: _____
Signature of Patient/Guardian/Authorized Representative

Witness of Above Signature: _____ Date: _____ Time: _____

*** Please furnish a copy of your conservator/guardianship papers or death certificate if beneficiary.**

THIS SECTION TO BE COMPLETED BY HOSPITAL EMPLOYEE AS TO CONTENT & METHOD OF RELEASE.

This consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance thereon and if not earlier revoked it shall terminate one (1) year from the date of signing.

- INFORMATION RELEASED FROM THE MEDICAL RECORD:**
- Discharge Summary Psychiatric History History & Physical
 - Progress Notes Physician Orders Laboratory Reports
 - Medication records Entire Record
 - Other

Records prepared by: _____ Date: _____

Date: _____ () mailed () picked up by: () Patient () other designated person listed above.

Logged in AIS by: _____ Date: _____