Cherry Health

Patient Request for Health Information

Patient Information:

Patient name: _____
First Middle Initial Last

Name at time of treatment (if different than above): _____

Date of birth: _____ Phone #: _____ Email (optional): _____

Address: _____
Street City State ZIP Code

What records are you requesting? Please check appropriate boxes below:

☐ Entire record
☐ Date(s) of service: _____ through _____
☐ Office notes
☐ Billing statements
☐ Test results (x-rays, lab results) Please specify: _____
☐ Immunization records
☐ Other (please specify): _____

How would you like your records delivered?

☐ Paper
  ☐ Mail
  ☐ In-person pickup
☐ Electronic (email, CD, other) Please specify: _____

Where would you like your records sent? Fill in boxes below:

Cherry Health should provide my records to: ☐ Patient ☐ Personal representative (indicated below)

Recipient name:	**Recipient phone #:** **Recipient fax #:**
Recipient mailing address:	**Recipient email (if applicable):**

Please print your name and sign below:

_____
Patient/Parent/Legal Guardian Signature **Relationship (please print)**

_____
Description of Legal Authority to Act on Behalf of Patient **Date/Time**

Please return completed form to:

Cherry Health
Health Information Management
201 Sheldon Blvd SE
Grand Rapids, MI 49503

Email: HIM@cherryhealth.com
Phone: 616.965.8282
Fax: 616.940.5367

Cherry Health recognizes a patient's right under HIPAA to access copies of the patient's health information. There may be charges associated with processing a request and producing requested records.

For staff use:
Completed by: _____