Print Clear

Please fill out all sections so your request does not get delayed.

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:	E-mail (optional):	
Street Address:	City:	State:	Zip:

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

***REQUIRED – WHICH HOSPITAL OR CLINIC/DOCTOR TO RELEASE FROM:** _____

Date(s) of Service: _____/_____/_____ through _____/_____/_____

☐ Billing Records ☐ Clinic Visit ☐ Discharge Summary

☐ Emergency Room Records ☐ Operative/Procedure Reports

☐ Test Results (X-Rays, Lab/Pathology Results) Please specify: _____

☐ Other (Immunization Records, Medication Lists) Please specify: _____

How would you like your records delivered?

☐ Paper

☐ Mail Delivery

☐ In-Person Pickup

☐ Electronic (Email, USB, CD, Portal, Other) Please specify: _____

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

SCL Health should provide my records to: ☐ Self ☐ Personal Representative (indicated below) ☐ Other Designated Third Party

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (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**

Please return completed form to:

Centralized Release of Information **SCL Health** **3655 Lutheran Parkway, Suite 304** **Wheat Ridge, CO 80033**	**E-mail: CROI@sclhealth.org** **Phone: 303-467-4046 • Fax: 303-467-8966** **Questions?**

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

SCL Health

0N107

Patient Request for Health Information

EH-FR-MR-4000-0321-SCLHS

PATIENT INFORMATION

Place label here.
Scanning does NOT work if label is outside this guide.