



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):	Home Phone:	Cell Phone (optional):	
Street Address:	City:	State:	Zip:

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

Date(s) of Service: ___/___/___ through ___/___/___ Location (Facility/Phys Office Name): _____

- | | |
|---|--|
| <input type="checkbox"/> Pertinent Information (Includes Physician Notes and Diagnostic Results) Entire Medical Record (Excludes Psychotherapy Notes) | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Other (Specify Below) | <input type="checkbox"/> Emergency Room Report |
| | <input type="checkbox"/> Operative Reports |

Specify: _____

INTEGRIS Health should provide my records to: Self Person/Organization Specified Below

Recipient Name:	Recipient Phone:
Recipient Mailing Address:	Recipient Fax (For Patient Care Only):

In what format would you prefer your records? (Check all that apply)

-
- Paper
-
- CD
-
- Radiology disc (for images)
-
- Portal (must choose portal as delivery method)

How would you prefer your records delivered?

-
- Mail
-
- Fax
-
- Portal (
- <https://www.integrisandme.com>
-)
-
- In Person Pick-Up:

-
- E-Mail (subject to file size limitations) _____ Location of Pick Up: _____

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:

INTEGRIS HIM Department 3366 NW Expressway, Bld D Ste. C20 Oklahoma City, OK 73112	Fax: (405) 552-8704
	Email: HealthInfoManagement@integrisk.com
	Questions? (877) 778-7211

There may be charges associated with processing a request and producing requested records pursuant to 45 CFR164.524(c)(4)

My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

NS-0321 HIM ROI Authorization



Rev 08/20, 03/22