



Guide and Instructions:

- Please complete the following form to request patient records.
- If the records are not for you, please provide documentation of your authority to receive them.
- Records will be accessible unless there is a legal exception.

Patient Information:

Last Name: _____ First Name: _____

Middle Name(s): _____ Maiden/Other Name(s) _____

Date of Birth (dd/mm/yyyy): _____ Phone Number: _____

Mailing Address: _____

Records Requested:

Please provide details of the records you require including the date, name of healthcare provider, service provided, etc. Depending on the records requested, a fee may apply.

Authorization:

I, _____, have the legal authority to make this request in my capacity as:

- The patient
- The patient's substitute decision maker (please include documentation proving authority)
- The Estate Trustee/Executor for a deceased patient (please include documentation proving authority)
- Other (please explain) _____

Signature: _____ Date (dd/mm/yyyy): _____

Staff Only:

Verbal consent obtained (Print name of LWDH Staff): _____

Signature: _____ Date (dd/mm/yyyy): _____

To be completed by LWDH staff member processing request:

Date Request Received (dd/mm/yyyy): _____

Date Request Processed (dd/mm/yyyy): _____

Guidelines:

1. Patient or substitute decision maker (SDM) must complete this form or submit a letter containing all required information. If the request is authorized, the LWDH employee will attach copies to the request.
2. LWDH Employee must date the form on receipt.
3. If the request is approved, health records staff will document the date processed on this form as well as in the Release of Information Meditech log.
4. Authorization form will be kept in the patient chart.