ST. Joseph's | Candler
www.sjchs.org

# PATIENT REQUEST FOR HEALTH INFORMATION

HEALTH INFORMATION MANAGEMENT DEPARTMENT


| ST. JOSEPH'S HOSPITAL | CANDLER HOSPITAL |
|---|---|
| 11705 Mercy Boulevard | 5353 Reynolds Street |
| Savannah, GA 31419 | Savannah, GA 31405 |
| PHONE: 912.819.2477 | PHONE: 912.819.6767 |
| FAX: 912.819.2136 | FAX: 912.819.6664 |


**Patient Information:**

Name________________________________________________ Date of Birth____________

Address______________________________ City________________ State_____ Zip__________

**What records do you need?** *(Check all that apply below)*

Date of Service__________________________

| | | | |
|---|---|---|---|
| ☐ Abstract | ☐ Emergency Room Record | ☐ Radiology Reports | ☐ Therapy Notes/Reports |
| ☐ Demographics | ☐ Cardiac Cath Report, Echo, EKGs | ☐ Radiology Images | ☐ Pathology Slides |
| ☐ Dictated Reports (H&P, OP Note, Discharge Summary, Consults) | ☐ Laboratory Reports | ☐ Medication Administration Record | ☐ Physician Office Notes/Forms |
| ☐ Other________________________________________ | | | |

**How would you like your records delivered?**

☐ Paper ☐ Mailed ☐ In-Person Pickup

☐ Electronic (email, Portal, Other) Please specify____________________________________

**Where do you want the records sent?** ☐ Self ☐ Personal Representative *(indicate below)*

| | |
|---|---|
| Recipient Name: | Phone: |
| Mailing Address: | Email Address: |

**Please print your name and sign below:**

Printed Name_______________________________________________ Date_________________

_______________________________________________ _________________

Signature of Patient or Personal Representative Relationship