AtlantiCare
REGIONAL MEDICAL CENTER

☐ AtlantiCare Regional Medical Center
☐ AtlantiCare Behavioral Health
☐ AtlantiCare Health Services
☐ AtlantiCare Surgery Center
☐ AtlantiCare Physicians Group
☐ Other ______

562

Patient Name: ______

Address: ______

Address: ______

Date of Birth: ______

Patient Phone No.: ______

MRN (if known): ______

PATIENT ACCESS REQUEST FORM

Please note: Charges may apply. Failure to remit payment of invoice may result in submission to a collection agency.

I request a copy of my medical information from the above checked facility for the time period of ______ ,to ______
("Present" equals date of signature).

SPECIFIC INFORMATION TO RELEASE: (Check box of items to be released).
*As defined by N.J.S.A. 2A:84A-22.18 -Reproductive health care services means all medical, surgical, counseling, or referral services relating to the human reproductive system including, but not limited to, services relating to pregnancy, contraception, or termination of a pregnancy.

☐ Abstract of Medical Record ☐ Complete Medical Record ☐ Clinic Notes ☐ Colonoscopy ☐ Consultation Reports
☐ Discharge Summary ☐ EEG, EKG, Stress Test ☐ ER Notes ☐ Endoscopy ☐ History & Physical
☐ Immunizations ☐ Itemized Bills ☐ Lab Reports ☐ Medications ☐ Operative Reports
☐ Pathology Reports ☐ Radiology Films/Reports ☐ Other ______

***FOR DISCLOSURE TO PATIENT ONLY: Do not use this form if you are requesting information relating to any testing, diagnosis and/or treatment of the conditions below AND you are instructing us to send this information to a third party. Please use an Authorization to Disclose Health Information or a comparable form instead.**

☐ **HIV/AIDS*** ☐ **Alcohol/Substance Use Disorder*** ☐ **Mental Health/Rehabilitation*** ☐ **Reproductive Health Care Services***

DISCLOSURE FORMAT: (Select box to indicate how you want to receive the information).

☐ Pick up (ID required) ☐ Review & Inspect ☐ US Mail (Paper) ☐ Email ______
☐ CD (secure .pdf) ☐ Fax (UNSECURE)** ☐ Other ______
(Please specify)

****If you elect to have your health information transmitted in an UNSECURE manner (i.e., unencrypted), AtlantiCare is not responsible for breach notification or liable for disclosures that occur in transit using potentially unsecure methods.**

RECIPIENT: Name: ______

Address of Individual or Organization: ______

______

Phone No: ______ Fax No: ______
(if applicable)

For disclosures to third party recipients, AtlantiCare is not liable for what happens to this health information once the designated third party receives the information as directed by the patient in this request.

SIGNATURES

Date: ______ ______
Patient Signature (If patient is unable to sign because of physical condition or age, complete the following):

Patient is a minor or patient or unable to sign authorization because: ______

Date: ______ ______ ______
Signature Relationship
(Parent/Guardian authorized under State law to make health care decisions for the patient).

Date: ______ Oral consent given: ______
Employee Signature