Erie Shores HealthCare
COMPASSIONATE CARE CLOSE TO HOME

REQUEST FOR ACCESS TO PERSONAL HEALTH INFORMATION

REQUESTOR'S INFORMATION:

Name of Patient	**Date of Birth (mm/dd/yyyy)**
Contact phone number	**Hospital ID number (if available)**
Name of Requestor if not the patient	**Relationship to patient (SDM).** **Please provide a copy of supporting documents**

ACCESS REQUEST:

1. **Please provide a detailed description of the personal health information you are requesting access to. Please provide dates, names of providers, etc. if applicable.**

_____
_____
_____
_____
_____

☐ **I would like in person access to view the records (requires appointment)**

☐ **I would like a copy of the requested information**

Signature of Patient/SDM	**Date (mm/dd/yyyy)**
Signature of Witness	**Date (mm/dd/yyyy)**

FOR ESHC USE ONLY:
Date Request Received: _____ Identification Validated: Yes No