Patient Request for Health Information

PRAIRIE STAR Health Center

PATIENT INFORMATION *(please print)*

PATIENT NAME (First, MI, Last)			
NAME AT TIME OF TREATMENT (If different than above)			
DATE OF BIRTH (MM/DD/YYYY)	PHONE	EMAIL (Optional)	
STREET ADDRESS	CITY	STATE	ZIP

WHAT RECORDS DO YOU WANT? *(check appropriate boxes below)*

DATES OF SERVICE: ____ / ____ / ____ through ____ / ____ / ____

- ☐ Office Visit Notes
- ☐ Billing Records
- ☐ Test Results (X-Rays, Lab/Pathology Results) Please specify: _____
- ☐ Other (Immunization Records, Medication List) Please specify: _____

HOW WOULD YOU LIKE YOUR RECORDS DELIVERED?

- ☐ Paper (no charge)
  - ☐ Home Delivery
  - ☐ In-Person Pickup
- ☐ Electronic
  - ☐ CD (additional $6.50)
  - ☐ Other (please specify): _____

WHERE DO YOU WANT THE INFORMATION SENT? *(complete appropriate boxes below)*

PrairieStar should provide my records to:

- ☐ Self
- ☐ Personal Representative (indicated below)

RECIPIENT NAME		PHONE	
RECIPIENT EMAIL (if applicable)		FAX	
RECIPIENT MAILING ADDRESS	CITY	STATE	ZIP

PATIENT SIGNATURE

PRINTED NAME OF PATIENT OR REPRESENTATIVE	RELATIONSHIP TO PATIENT	
SIGNATURE OF PATIENT OR REPRESENTATIVE	DATE	TIME

Please return completed form to:

PrairieStar Health Center
Health Information Management Department
2700 East 30th Ave.
Hutchinson, KS 67502

Email: HIMdepartment@prairiestarhealth.org
Fax: 620-663-9526
Phone: 620-663-8484

PrairieStar Health Center recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.