ROPER ST. FRANCIS PHYSICIAN PARTNERS

PATIENT REQUEST FOR ACCESS FORM

This form may be used when a patient requests a copy of their information for themselves, for another provider, or for family member or friend. All other requests should be submitted on Authorization to Release of Protected Health Information Form.

I am a patient of Roper St. Francis Physician Partners (RSFPP) and my information is listed below:

Patient Name: _____ Date of Birth: _____

Street Address: _____ Last 4 numbers of SSN: _____

City, State, Zip: _____ Telephone: _____

Email address: _____

By providing your email address, you acknowledge and accept the risks outlined in Guidelines for E-mail with Patients, posted on rsfh.com.

I would like for _____ _____

List name of physician or practice practice(s) or select all RSFPP physicians

Choose one:

- ☐ **Give me a copy of my health information, or**
- ☐ **Send my records to:**

_____

(Name of Person, Facility, Company) (Street Address or PO Box, City, State, Zip Code)

_____

(Phone Number) (Fax Number)

_____

(E-mail Address)

I would like these dates of service to be released: _____

I want these parts of my record to be released (check all that may apply):

☐	Office/Clinic Summary	☐	Emergency Services Record
☐	Discharge Summary	☐	Operative Report
☐	History and Physical	☐	Laboratory Report
☐	Entire Records	☐	Radiology/X-Ray Reports
☐	Itemized Bill	☐	Other _____

I want these records in the following format (choose one): ☐ Thumb Drive ☐ CD ☐ E-mail ☐ Paper ☐ Other _____

I want you to send the records by (choose one): ☐ Mail ☐ Secure E-mail ☐ Fax ☐ Prepare them to be picked up by_____

As an alternative, you may schedule an appointment with your healthcare provider's office to see your record in person. Please note it may take up to 30 days to schedule the appointment or provide copies.

Signature: _____ **Print Name:** _____

Relationship to Patient: _____ **Date:** _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign for the patient (written proof may be requested).

RETURN COMPLETED FORM IN PERSON TO YOUR PROVIDER OR RETURN BY MAIL, E-MAIL OR FAX WITH A COPY OF YOUR PHOTO I.D.

Roper St. Francis Physician Partners
Attention: Release of Information Department
8536 Palmetto Commerce Parkway, Ladson, SC 29456
Phone: (843) 402-5015 Fax: (770) 810-9127
Email: RSFPPROI@RSFH.COM

Origin: 3/17