The Medical Center of Southeast Texas
Patient Request to Inspect and/or Obtain a Copy of Protected Health Information

I desire access to and/or copies of medical information created and maintained by The Medical Center of Southeast Texas. I authorize The Medical Center of Southeast Texas to copy and/or disclose to me my health information.

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

PURPOSE FOR USE / DISCLOSURE _____

Approximate date(s) of service to be used/disclosed _____

INFORMATION TO BE USED / DISCLOSED

- ❑ Consultation Report(s)
- ❑ Emergency Room Record
- ❑ Operative/Procedure Report
- ❑ Other _____
- ❑ Discharge Summary
- ❑ History and Physical
- ❑ Pathology Report
- ❑ EKG Reports(s)
- ❑ Lab Reports
- ❑ Radiology Reports / films

In which form do you wish to receive a copy of your records?

- ❑ Paper
- ❑ Electronic (.pdf)
  - → including the Continuity of Care Document

I understand that this information may include information relating to: Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV): treatment for drug or alcohol abuse; or mental or behavioral health or psychiatric care, excluding psychotherapy notes.

I desire access to my protected health information as follows:

1. The information identified above should be sent to me at the following address:

Address _____ City _____ State _____ Zip _____

2 I would like to pick up the information noted above on the following dates and time:

Date _____ Time _____

3 I want to review my protected health information, but I do not need a copy. I would like to review the information noted above on the following date and time:

Date _____ Time _____

I understand that The Medical Center of Southeast Texas may charge a fee for the cost of copying, mailing, or other supplies associated with this request (not to exceed the community standard), and such fees must be paid in advance.

I understand that The Medical Center of Southeast Texas may deny my request to inspect and obtain a copy of my protected health information in certain limited circumstances. I understand that if I am denied the opportunity to inspect and obtain a copy of my protected health information, I may request that the denial be reviewed in certain situations.

Signature of Patient or Patient's Representative _____ Printed Name of Patient or Patient's Representative _____

Relationship to Patient _____ Date _____ Daytime Telephone Number _____

Account Number:	MR Number:
Patient Name:	
Admit Date:	

DOB	Age	Sex	HT	WT	RM-BD	PT	SVC	FC

Allergies:

Attending Physician Name:

The Medical Center OF SOUTHEAST TEXAS
2555 Jimmy Johnson Blvd. - Port Arthur - Texas 77640
(409) 724-7389