Chestnut Hill Hospital • 8835 Germantown Ave • Philadelphia, PA 19118-2718

Patient Request for Health Information

Patient Information (Please print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

What records do you want? (Check appropriate boxes below):

Date(s) of Service _____/_____/_____ through _____/_____/_____

☐ Discharge Summary ☐ Emergency Room Records ☐ Operative/Procedure Reports ☐ Billing Records

☐ Test Results (X-Rays, Lab/Pathology Results) Please specify: _____

☐ Other (Immunization Records, Medication Lists) Please specify:_____

☐ Complete Medical Record ☐ Radiology Studies/Images ☐ Abstract

How would you like your records delivered?

☐ Paper
- ☐ Home Delivery
- ☐ In-Person Pickup

☐ Electronic (E-mail, CD, Portal, Other)
Please specify:_____

Where do you want the information sent? (Fill in boxes below):

Chestnut Hill Hospital should provide my records to: ☐ Self ☐ Personal Representative (indicated below)

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (if applicable):

Please print your name and sign below:

Name of Patient or Personal Representative (Please print)	Relationship (Please print)
Signature of Patient or Personal Representative	Date/Time

Please return completed form to:

	E-mail: Fax:
	Questions?

Chestnut Hill Hospital 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.