



**BENSON  
HOSPITAL**  
PO Box 2290  
Benson, AZ 85602  
(520) 586-2261

## **PATIENT REQUEST FOR RECORDS**

**NAME OF PATIENT:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**IF YOU ARE NOT THE PATIENT:**

What is your name \_\_\_\_\_

Your relationship to the patient \_\_\_\_\_

What gives you the authority to receive the patient's information?

- \_\_\_ Written authorization from the patient (please attach)
- \_\_\_ You are the patient's parent or legal guardian
- \_\_\_ You are the patient's health care decision maker (please attach evidence such as Medical Power of Attorney)
- \_\_\_ The patient is deceased and you are the personal representative of the patient's estate (please attach evidence)
- \_\_\_ Other (please explain)

**INFORMATION REQUESTED**

- \_\_\_ Written medical records for hospital visit dated: \_\_\_\_\_
- \_\_\_ X-rays for visits dated: \_\_\_\_\_
- \_\_\_ Billing records for hospital visits dated: \_\_\_\_\_
- \_\_\_ A summary of medical records (history and physical, discharge summary and progress notes for each visit(s) dated: \_\_\_\_\_
- \_\_\_ Emergency Room records for visit(s) dated: \_\_\_\_\_
- \_\_\_ Other: Explain \_\_\_\_\_

**CHARGES FOR INFORMATION**

Written medical records and billing records will be copied at a charge of \$2.00 for the first 10 pages and 20 cents for each additional page.  
Payment for records is due upon receipt of the records.  
There are no charges for records for patient care use.



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**METHOD OF DELIVERING INFORMATION**

\_\_\_\_ I will pick up the records at the Health Information Management Department.

\_\_\_\_ Please mail the records to me to: \_\_\_\_\_  
at: \_\_\_\_\_

\_\_\_\_ Please mail the records to: \_\_\_\_\_  
at: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_ I will review my original records onsite in the Health Information Management Department. I will call the HIM Dept. at (520) 586-2261 to arrange a time to do so.

I am authorized to receive copies of the medical and billing records for \_\_\_\_\_ .  
I understand that I will be charged as set forth above for the copies of the records I have requested. I agree to pay the total charges upon receipt of the copies.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

This authorization shall be in effect for 90 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving written notice.