Penn Medicine
Lancaster Rehabilitation Hospital
Lancaster General Health

PATIENT REQUEST FOR ACCESS TO CONFIDENTIAL INFORMATION

Patient Information	Name: _____ Date of Birth: _____ Last 4 digits of SS#: _____ Address: _____City: _____ State: _____ Zip:_____ Day Phone: _____
Hospital Name	
Receiving Party (Where and to whom do you want the records sent?)	☐ Me ☐ Other Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Day Phone: _____ Fax Number: _____ Email Address: _____
Information to be Released (What do you want? Check the appropriate boxes)	Customary charges apply based on selection of items below. Please obtain estimate of cost at time of request. Dates of Service: _____ ☐ Inpatient Routine Record Set (includes: History & Physical, Consultations, Discharge Summary) ☐ Billing Records ☐ Entire record ☐ Individual Reports: _____ (list)
Release Instructions: (How and When do you want the information?)	Date information is needed: _____ (Note: PLEASE ALLOW 30 DAYS FOR PROCESSING) Release Method Requested: ☐ Paper ☐ CD/DVD ☐ Fax _____ ☐ Unsecured e-mail _____ ☐ Other _____ (Requests for other methods of delivery will be reviewed on a case by case basis)

_____ _____ _____
Patient/Legal Guardian Signature Date/Time Authority to act on behalf of patient (attach document)

Released by: _____(name/title)