PATIENT'S REQUEST FOR ACCESS TO BILLING RECORDS

Date: _____ M.R. # or Account if known: _____

Patient Name: _____ AKA/ other names: _____

Date of Birth: _____ Phone: _____

Address: _____City/State/Zip_____

Hospital/Facility Name: _____
(Required)

Covering the period of healthcare from *(date)* _____ to (*date)* _____

You have requested access to billing-related health information about you. To enable us to process your request for a billing statement, please read the following carefully and complete the requested information below.

Select documents being requested:

☐ Itemized Statement ☐ Other_____

Select your preference for receiving these documents:

☐ Mailed to address on statement

☐ Send Secure Email to: _____

☐ Send Non-Secure Email to: _____

NOTE: We encourage you to use secure email because it better protects your privacy, but we will send to your (non-secure) email address if you tell us to do so.

Patient's Right to Direct Billing Statement to Another Person. You have the right to ask us to send your billing statement to a person of your choice. If you want us to send your records to someone else, please give that person's name and full address here:

_____
Print Person's First Last Name

Address: _____City/State/Zip_____

If you ask to have a billing statement sent to another person and the statement may refer to these types of information, please initial each applicable item to confirm your request. Certain types of health information are specially protected under state or other laws. Some itemized billing statements may refer to payment for those specially protected types of information.

_____ Mental health records
_____ Substance abuse treatment information
_____ HIV related information and other communicable diseases
_____ Genetic testing information

This request will be processed in the order received.

_____	_____
Patient or Personal Representative's Signature	Date
_____	_____
Print Name	Telephone #
_____	_____
Relationship to Patient of Personal Representative	Evidence of authority (Power of Attorney Document, etc.)

Return this document to one of the following:

Mercy Redding
mmcr-him@commonspirit.org

Mercy Mt Shasta
mmcmsroi@commonspirit.org

St Elizabeth
sechroi@commonspirit.org