ST. JOSEPH MERCY CHELSEA
SAINT JOSEPH MERCY HEALTH SYSTEM

PATIENT REQUEST FOR MEDICAL RECORDS

Health Information Management
775 S. Main Street
Chelsea, MI 48118

Phone (734) 593-6310
Fax (734) 593-6315

Patient Name: (Last)_____ (First)_____ (M.I.)____

Address: (Street/Box)_____ (City)_____ (State)_____ (Zip)_____

Telephone: Home_____ Cell_____

Date of Birth:_____

I request St. Joseph Mercy Chelsea Hospital to provide me with a copy of my medical records.

INFORMATION REQUESTED

Types and Dates of Records Requested

- ☐ Emergency Room Records of : _____
- ☐ Discharge Summary (Inpt) Date(s): _____
- ☐ History & Physical _____
- ☐ X-ray Reports from: _____ to: _____
- ☐ Lab Reports from: _____ to: _____
- ☐ Outpatient Records - Specify type and dates: _____
- ☐ Others _____

_____ _____ _____
Signature of Patient or Personal Representative Date Time

If Personal Representative, state relationship:_____

☐ Photo ID Verified ☐ Completed by:_____ _____ _____
Date Time