Patient Request for Health Information

The undersigned patient or personal representative hereby requests:

- ☐ To obtain an electronic copy of the medical record or films on encrypted media as applicable, including CD or USB, for the patient named below; or
- ☐ To obtain a paper copy of the medical record for the patient named below.

Patient Name _____Date of Birth_____

Address _____

City/State/Zip_____

Telephone _____ Fax Number _____
(Include area code) *(Include area code)*

For service dates from _____ to _____

Specific document/results/encounter requested _____

Christus Health of Southern New Mexico will provide patients with access to the requested healthcare information unless there exists a valid reason to deny the information based on the 21st Century Cures Act Exception. Christus Health of Southern New Mexico will make every effort to fulfill a patient request as quickly as possible. Christus Health of Southern New Mexico's HIM Department ***may*** be able to fulfill the request at the time it is made, but there may be instances where staff will need to arrange a pick-up date with the patient or send information by mail.

Print Name:_____
(If Personal Representative, include a description of authority to act for patient)

Signature: _____***Date:***_____

State issued photo ID is required when requesting records.

Return this **completed** form to Christus Health of Southern New Mexico's Health Information Management (HIM) Department.
If you have any questions, please call 575-443-7800

For CSNM Use Only: Date that this request was received by CSNM _____

Date of Disclosure: _____ MRN: _____

Request Disposition: _____ Approved _____ Denied

CHRISTUS Southern New Mexico