Mt. Washington Pediatric Hospital

Patient Request for Medical Records

This form is for use only by the patient or personal representative to request copies of medical records.

Patient Name: _____ Date of birth (MM/DD/YYYY): _____

Address: _____ Phone: _____

Indicate the specific information you are requesting:

□ Inpatient Abstract (history and physical, discharge summary, lab, radiology and other diagnostic testing)

□ Discharge Summary	□ Progress Notes	□ Mental Health Records
□ History and Physical	□ Immunization Records	□ Radiology Images (CD/DVD)
□ EKG/Cardiology Reports	□ Rehabilitation Evaluations	□ Billing Records
□ Lab/Radiology Reports	□ Consultation Reports	□ Other _____
	□ Outpatient Clinic Notes	

Please indicate the date(s) of service _____

Mt. Washington Pediatric Hospital should send my medical records to:

Recipient Name: _____

Address and Telephone Number: _____

_____

How would you like your records delivered? (please check the format below)

☐ PAPER ☐ CD ☐ USB (flash drive) ☐ FAX _____ ☐ E-MAIL _____

** A fee may be charged for copies of the medical record. (please print)

Please print your name and sign below:

_____/_____

Name of Patient or Personal Representative (please print) Date

_____/_____

Signature of Patient or Personal Representative Date

Please check the appropriate box:

☐ Parent with Parental Rights ☐ Patient is 18 or older ☐ Court Appointed Guardian**

☐ Registered Kinship Care Relative** **Note: You must attach proof of your authority to act on behalf of the patient.

Fax the completed form to: 410-578-0567 or return by mail to: Mt. Washington Pediatric Hospital – Attn: HIM Dept.
1708 W. Rogers Avenue
Baltimore, Md. 21209-4596