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REQUEST FOR ACCESS TO PATIENT'S HEALTH INFORMATION

Please allow approximately one week to process your request after completing this form.

Requested By:

Name of Patient: _____ DOB: _____
Address: _____ Phone No: _____
City, State, Zip: _____ SSN: _____

Records to Come From:

Name: _____ Phone No: _____
Address: _____ Fax #: _____
City, State, Zip: _____ Date Records Required: _____

To be released to: circle one: Mail Fax I will Pick up Records

Name: _____ Phone No: _____
Address: _____ Fax #: _____
City, State, Zip: _____ Date Records Required: _____

Reasons for Request: Changing Doctors/Practices another Doctor Consultation for own Use

Requested Records: Entire Chart Partial Chart-Date Range: _____ to _____
 Labs: _____

Printed Name of Patient or Representative if patient is a minor Relationship

Signature of Patient or Representative if patient is a minor **Picture ID required upon pick-up of PHI**

Witness Date of Request

As a patient of Rosemark WomenCare Specialists, you are entitled under Federal law to access your **Personal Health Information (PHI)**. Your records are protected and cannot be disclosed without your written permission. If you have any questions or concerns regarding the handling of your PHI, or if you wish to view your PHI, contact our Privacy Officer at (208) 557-2940.