TRELLIS Supportive Care
Palliative • Hospice • Family Support

Trellis Supportive Care Patient Request for Access Form
Grief Counseling Services

Patient Name: _____Date of Birth: ____/____/_____ Patient #_____
Address: _____City: _____ State: ____ Zip: _____
Email Address: _____Phone_____

I hereby request access to medical records from Trellis Supportive Care for:

☐ All dates of service ☐ Dates of Service from _____ to _____

Information requested:

☐ I am requesting to review my medical records in person.
☐ I am requesting a copy of the following from my medical record:
☐ Entire Record
☐ Billing Record
☐ Other _____

Method of Delivery:

☐ Copies will be picked up by _____at Trellis Supportive Care
☐ Mail copies to the following address: _____
☐ Fax copies to the following fax number:_____
☐ Send via encrypted email to the following email address: _____
☐ Send unencrypted email address: _____
I understand that transmission of unencrypted email over the internet is at risk for interception by unauthorized individuals and is not recommended. I request an unencrypted email and accept the risk. _____ (initial)

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____
Patient or Authorized Personal Representative Date

If signed by Personal Representative, complete the following:

_____ _____
Print Name Authority of Personal Representative
(POA, HCPOA, Executor of Estate, Guardian, Next of Kin)

If you are not the patient, you MUST attach documentation of your authority to act on behalf of the patient.

Please send the completed request for access form to:
Mail: Attention: Medical Records, Trellis Supportive Care, 101 Hospice Lane, Winston-Salem, NC 27103
Email: medicalrecordrequest@trellissupport.org **Fax Number:** 336-673-6025 **Phone Number:** 336-331-1258

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