



PATIENT LABEL

415 Jefferson St. N., Wadena, MN 56482  
218-631-3510 ROI Fax: 218-631-7571

First Name		Middle Initial	Last Name	Maiden/Other
Email Address				
Date of Birth	Home Phone		Cell phone	
Street Address	City/State		Zip Code	

I am requesting a copy of my health records that are maintained by Astera Health for my personal review. I am requesting records for **date(s) of service from:** \_\_\_\_\_ **to:** \_\_\_\_\_

**Please select documents:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Emergency Room Records    | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History and Physical                 |
| <input type="checkbox"/> Operative Reports         | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Test Results (EKG, Echo, X-ray, lab) |
| <input type="checkbox"/> Immunizations/Medications | <input type="checkbox"/> Clinic Notes      | <input type="checkbox"/> Other _____                          |

**How would you like your records delivered to you? Please indicate below:**

- |  |  |
|--|--|
| <input type="checkbox"/> MyChart           | <input type="checkbox"/> US Mail (paper)                                   |
| <input type="checkbox"/> Secure Email      | <input type="checkbox"/> Pick-up in person (call 218-631-5231 to schedule) |
| <input type="checkbox"/> Non-secure email* | <input type="checkbox"/> US Mail (DVD/CD)                                  |

**\*NOTE: I acknowledge that by electing to receive my health information via email in a non-secure manner that the information will not be encrypted, and that it could be intercepted and viewed by a third party. Astera Health is not responsible for unauthorized access of your health information while in transmission to the email address you designated above.**

- A request for substance use disorder treatment record requires a separate authorization.
- A patient will not be charged a fee for the first copy of the patient record but may be charged for additional copies of the same record.
- If records are unable to be emailed due to size limitations, records will be sent via DVD/CD.

Please sign and date below

Patient Signature		Date
Signature of Personal Representative	Relationship	Date

Please return completed form to:

**Attn: HIM Department**  
**Aster Health**  
**415 Jefferson St. N., Wadena, MN 56482**  
**ROI Fax: 218-631-7571**