PATIENT'S REQUEST TO ACCESS PROTECTED HEALTH INFORMATION ("PHI")

PHI Requested from:

☐ Community Hospital of Staunton **Health Information Department** **400 Caldwell Street** **Staunton, IL 62088** **Release of Information (618) 635-4257** **Fax (618) 635-4354**	Community Hospital OF STAUNTON	☐ **Community Memorial Clinic** **325 North Caldwell Street.** **Staunton, IL 62088** **Phone (618) 635-2221** **Fax (618) 635-2269**

Patient's Name _____ **Patient's Date of Birth** _____

Patient's Address/Phone _____

PHI to be released/accessed:

☐ Final Diagnosis	☐ Radiology Reports	☐ Radiology Images **Circle One: Disc Film**
☐ Discharge Summary	☐ Laboratory Reports	☐ Physician Orders
☐ History / Physical	☐ EKG	☐ Emergency Record
☐ Consultation Reports	☐ Pathology Reports	☐ Entire Record
☐ Operative Reports	☐ Progress Notes	☐ Employee View Only Access
☐ Cardiology Reports	☐ Abstract	☐ Other

Date(s) of Service of Records Requested: From Date: _____ To Date: _____

If PHI requested contains information about drug/alcohol abuse, mental health treatment, genetic information, sexually transmitted diseases, HIV/AIDS testing/treatment or any other sensitive information, I request that this information be released. Check if you are not requesting release of sensitive information described herein: ☐ **Do Not Release**

Specify the information NOT to be released: _____

I request that records be provided in the following format (if readily reproducible in this format):

☐ Paper Copy ☐ Electronic Copy via (check below)

☐ *CD* ☐ *Encrypted E-Mail (to e-mail address below)* ☐ *Unencrypted E-Mail (to e-mail address below)*

I request that records specified above be provided:

☐ To patient ☐ To the following person/entity: _____

I request that access to records be provided by:

☐ Personal pick-up or inspection

☐ Mailed to: _____

☐ Emailed to: _____

☐ Faxed to_____

☐ Other:_____

ACKNOWLEDGMENT: I understand that the CD is not encrypted and that I am responsible for protecting information on the CD. I also understand that unencrypted e-mail is not secure and while in transit it can be intercepted and seen by others. By requesting to receive my PHI electronically on a CD or by unencrypted e-mail I acknowledge that I understand and accept these risks.

I understand that I may be charged a reasonable fee for the costs of labor for copying, postage, supplies as permitted by HIPAA Privacy Rule and state law. I will be informed in advance of the approximate fee that may be charged for copy of PHI I requested.

Printed Name: _____

Signature: _____ Date: _____

Requested by: (Check One)

☐ Patient ☐ Personal Representative (Documentation Attached)

☐ Parent ☐ Legal Guardian (Documentation Attached)

Internal Use Only

Visit #:_____ M# _____

Request #: _____ Pg Count: _____

Photo ID Verified: ☐ Yes ☐ No

Processed by: _____