


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

**PHI Requested from:**

<input type="checkbox"/> Community Hospital of Staunton Health Information Department 400 Caldwell Street Staunton, IL 62088 Release of Information (618) 635-4257 Fax (618) 635-4354		<input type="checkbox"/> Community Memorial Clinic 325 North Caldwell Street. Staunton, IL 62088 Phone (618) 635-2221 Fax (618) 635-2269
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**Patient's Name** \_\_\_\_\_ **Patient's Date of Birth** \_\_\_\_\_

**Patient's Address/Phone** \_\_\_\_\_

**PHI to be released/accessed:**

<input type="checkbox"/> Final Diagnosis	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Radiology Images <b>Circle One: Disc Film</b>
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Physician Orders
<input type="checkbox"/> History / Physical	<input type="checkbox"/> EKG	<input type="checkbox"/> Emergency Record
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Entire Record
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Employee View Only Access
<input type="checkbox"/> Cardiology Reports	<input type="checkbox"/> Abstract	<input type="checkbox"/> 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)

<b>Internal Use Only</b>	
Visit #: _____	M# _____
Request #: _____	Pg Count: _____
Photo ID Verified: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Processed by: _____	