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

**PHI Requested from:**

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