

## PATIENT'S REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION - A

Date: \_\_\_\_\_ M.R. # or Account #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ AKA/Other names: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Covering the period of healthcare from (date) \_\_\_\_\_ to (date) \_\_\_\_\_

You have requested access to health information about you. To enable us to protect your request, please read the following carefully and complete the requested information below.

**There may be fees associated with your request.** The form in which you access your information may determine the amount of such fees.

A. You would like access to the health information about you maintained by Saint Mary's Medical Center as follows (*Check one*).

- inspect only
- copy only (*Fees may apply. See attached price list.*)
- inspect and copy (*Fees may apply. See attached price list.*)

B. You may obtain the following in lieu of a copy of the medical records:

- written summary of health information (*Fees may apply. See attached price list.*)

C. Tell us which type of health information you want to access (*Check all that apply*):

- |  |   |
|--|---|
| <input type="checkbox"/> Complete Health Record(s)             | <input type="checkbox"/> Emergency Room Records |
| <input type="checkbox"/> Discharge Summary                     | <input type="checkbox"/> History and Physical   |
| <input type="checkbox"/> Progress Notes                        | <input type="checkbox"/> Consultation Reports   |
| <input type="checkbox"/> Laboratory Tests                      | <input type="checkbox"/> Billing Records        |
| <input type="checkbox"/> X-ray Reports                         |   |
| <input type="checkbox"/> Other ( <i>please specify</i> ) _____ |   |

The following classes of information are protected by special privacy laws and access may be subject to special rules or may be restricted under certain circumstances or access may require consultation with your physician or healthcare provider responsible for your care before release. If you are requesting access to records relating to any of the following, please initial each applicable item to confirm your request.

\_\_\_\_\_  
Initial HIV (Human Immunodeficiency Virus) Test Results (**To be released upon approval of your physician**)

\_\_\_\_\_  
Initial Psychiatric care (**To be released upon caregivers approval. See page 2**)

\_\_\_\_\_  
Initial Treatment for alcohol and/or drug abuse



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## PATIENT'S REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION - A

All patients' (or personal representative's) request(s) for access to their health information are processed in the order received. Upon the hospital's receipt and review of your request, we will contact you for a time and place when and how you may inspect and/or obtain a copy of the records requested.

This request for access will not require St. Mary's Medical Center to provide health information about you to anyone other than to you or your personal representative. If you request us to disclose health records or information about you to some other person, we may need a signed authorization (a different form) from you to enable us to transmit such information.

**I have read and confirm the terms of access stated herein.**

\_\_\_\_\_  
Patient or Personal Representative's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name if Other Than Patient

\_\_\_\_\_  
Telephone #

\_\_\_\_\_  
Relationship to Patient or Personal Representative

\_\_\_\_\_  
ID Presented

\_\_\_\_\_  
Name of hospital employee verifying signatory information

\_\_\_\_\_  
Title and Department

### FOR PSYCHIATRIC OR MENTAL HEALTH RECORDS

### CAREGIVER'S APPROVAL TO RELEASE OF INFORMATION

The undersigned, the physician, licensed psychologist or social worker with a master's degree in social work, who is in charge of the patient \_\_\_\_\_ hereby  approves  disapproves the release of information and records to the patient or personal representative specified herein.

(NOTE: If disclosure is disapproved, give reasons below and note any restrictions to the release of records. No approval is required for release to the patient's attorney, unless the request is for the use or disclosure of information given in confidence by the patient's family.)

\_\_\_\_\_  
Signature: \_\_\_\_\_

\_\_\_\_\_  
Degree: \_\_\_\_\_

\_\_\_\_\_  
Print Name: \_\_\_\_\_  
(physician, psychologist, social worker)

\_\_\_\_\_  
Telephone: \_\_\_\_\_

\_\_\_\_\_  
Date: \_\_\_\_\_