Date: I	MR # or Account #:	
Patient Name:	_ AKA/ Other names:	
Date of Birth:	Phone:	
Address:	City/State/Zip	
Covering the period of health care from (date)	(date)	
You have requested access to health information please read the following carefully and complete	on about you. To enable us to process your request, te the requested information below.	
There may be fees associated with your requinformation may determine the amount of such	· · · · · · · · · · · · · · · · · · ·	
A. You would like access to the health informa Center as follows: (Check one).	tion about you maintained by Mercy Medical	
inspect only		
copy only (Fees may apply. See attack	ched price list)	
☐ Paper ☐ Electronic:		
-	Email Other:	
inspect and copy (Fees may apply. Se		
B. You may obtain the following in lieu of a co	opy of the medical records:	
_	on (Fees may apply. See attached price list)	
C. Tell us which type of health information you Patient Center) (Check all that apply):	a want to access (Not Applicable for Online	
☐ Complete Health Record(s)	☐ Emergency Room Records	
☐ Discharge Summary	☐ Progress Notes	
☐ History and Physical	☐ Laboratory Tests	
☐ Consultation Reports	☐ X-ray Reports	
☐ Billing Records		
Others (please specify)		





A PATIENT'S REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

D. ONLINE PATIENT CENTER/PATIENT PORTAL  Email Address:	ACCESS ONLY
The following classes of information are protected by special prosubject to special rules or may be restricted under certain circum consultation with your physician or health care provider responsify you are requesting access to records relating to any of the folloapplicable item to confirm your request.	nstances or access may require sible for your care before release.
Mental health or developmental disability treatment renotes")	cords (excludes "psychotherapy
Substance abuse treatment records	
HIV test results (This authorizes disclosure of laborato your records may include information concerning your F initial this line.)	· ·
All patients' (or personal representative's) request(s) for access processed in the order received. Upon the hospital's receipt and contact you for a time and place when and how you may inspec records requested.	review of your request, we will
This request for access will not require Mercy Medical Center t about you to anyone other than to you or your personal represer disclose health records or information about you to some other authorization (a different form) from you to enable us to transm	ntative. If you request us to person, we may need a signed
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 of Personal Representative	ID Presented
Name of hospital employee verifying signatory information	Title and Department





A PATIENT'S REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

## <u>FOR PSYCHIATRIC OR MENTAL HEALTH RECORDS</u> CAREGIVER'S APPROVAL TO RELEASE OF INFORMATION

(Hospital use only)
Approved Approved, subject to the following restrictions:
☐ Denied, reason for denial:
(NOTE: Access may only be restricted or denied if you believe that providing access is reasonable likely to endanger the life or physical safety of the patient.)
Signature: Role:
(physician, psychologist, social worker)
Date: Telephone Number:





A PATIENT'S REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION