

Patient:

I _____ request access to my protected health information contained in the medical records or billing records maintained by St. Joseph Hospital to review the contents and obtain copies.

Or

Patient's Personal Representative:

I _____ request access to the protected health information of _____ contained in the medical records or billing records maintained by St. Joseph Hospital to review the contents and obtain copies. I have the right to inspect and request copies of whatever portions or the entirety of the health records as well as to request a summary explanation of these records. I understand this request will require the collection of these records and that St. Joseph Hospital will arrange a convenient time and place for me to conduct my review of this protected health information. I request access and/or copies/summaries of the following information:

From (date) _____ to (date) _____ Account number _____

From (date) _____ to (date) _____ Account number _____

Please check type of information to be accessed/copied:

<input type="checkbox"/> Entire medical record	<input type="checkbox"/> Pathology report	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> History and physical exam	<input type="checkbox"/> Consultation reports	<input type="checkbox"/> Progress notes
<input type="checkbox"/> Laboratory test results/reports	<input type="checkbox"/> X-ray reports	<input type="checkbox"/> X-ray films / images
<input type="checkbox"/> Operative report	<input type="checkbox"/> Emergency room record	<input type="checkbox"/> Itemized bill

Other, (specify) _____

I would like the protected health information to be provided in (check one):

- ____ Photocopy format
- ____ Summary explanation format _____

And provided to me by the following method (check one):

- ____ Personal pick-up
- ____ US Postal Service to (Address) _____
- ____ Other, specify: _____

I understand that if this is an "Open" Record the Protected Health Information is considered incomplete and the charts are being used to record the care and treatment of an inpatient or an active outpatient. These records are under development.

Signature _____ Date: _____

Printed Name _____

Relationship if not Patient _____

Patient's Date of Birth: _____ Patient's Social Security Number: _____

Patient's Address: _____

Patient's Telephone Number: _____

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For Facility Use Only:

Identity of Requestor Verified via: ___ Photo ID ___ Matching Signature ___ Other, specify _____

Verified by: _____

St. Joseph Hospital



Form Number 4200-0008-8s Rev. 03/15/05

PHI - Patient Request for Access

