PATIENT REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Date of Request:_______________________________

Please fill in the following information:

Patient Name:		
Birth Date:	SS#	
Patient Address:		
City:	State:	Zip Code:
Home Phone Number:	Work Phone Number:	

I request access to the following Protected Health Information about me at the □ Hospital and/or □ Physician/Medical Practice:_______________ ______________________________: Treatment beginning ___________________________ to ___________________________.

Check one:

□ Discharge Summary □ Laboratory Data □ Entire Medical Record □ Abstract Medical Record
□ Operative Report □ EKG □ Emergency Room Record □ Pathology Report
□ X-Ray Report □ Other (specify)____

Check one:

□ I wish to review my Protected Health Information at the Hospital
□ I wish to review a copy of my Protected Health Information
  □ mailed to the address listed above in the below format; or
    □ Paper □ CD □ Flash Drive
  □ for me to pick up at the hospital in the below format; or
    □ Paper □ CD □ Flash Drive

□ I wish for my Protected Health Information to be delivered to secure portal via CIOX eDelivery Online Service – instructions for accessing my records to be sent to the below email address
□ I wish for my Protected health Information to be delivered via MyChart
  □ also authorize to release and make this information available to my proxy in MyChart:____________________________
  (Specify Name of Proxy)

PLEASE READ BELOW TERMS AND CONDITIONS PRIOR TO REQUESTING eDelivery OPTION

I understand and agree that:

- I must provide a valid email address, either my own or that of my designated recipient.
- My records will be provided as Adobe PDF files on the **eDelivery** website.
- I will receive an email containing instructions for accessing my records.
- There may be a fee for collecting my records. If so, an invoice will be included with the records.

Email Address:

I understand that PHI may include information protected under law, such as alcohol or drug abuse treatment information, mental health related communications or treatment information, or information regarding sexually transmitted diseases including HIV or AIDS testing or treatment. I understand the PHI may include health information records of the patient disclosed to University by other health care providers. This authorization does not limit University's Notice of Privacy Practices.

I understand that the Hospital or authorized copy service may charge me a reasonable, cost based copying fee if I request a copy of my protected health information, including a fee for labor and supplies (including the cost of the CD and/or flash drive, if requested). I will have to pay postage charges if I request the Hospital to mail the copy to me. I am responsible for paying these fees; this service is not covered by insurance. I may withdraw or change request if I do not want to pay these fees.

Person authorized to pick up records on patient behalf:_______________________________________

Patient Signature:_______________________________________Date:____________________