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

PHI Requested from: Check appropriate box

☐ **Anderson Hospital**	☐ **Anderson Medical Group**	☐ **Maryville Imaging**
Health Information Department **6812 State Route 162 – Suite 175** **Maryville, IL 62062** **Release of Information (618) 391-6102** **Fax (618) 288- 0024**		**2023 Vadalabene Dr.** **Ste. 100** **Maryville, IL 62062** **Phone (618) 288-4929** **Fax (618) 288-4531**

Patient's Name _____ Patient information including Name; Date of Birth _____ **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

Information to be released/accessed.

Date(s) of Service of Records Requested: From Date: _____ To Date: _____ Date range of records requested

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): Select 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: _____ Name of individual to receive/access information _____

I request that access to records be provided by:

☐ Personal pick-up or inspection ☐ Faxed to: _____

☐ Mailed to: _____ Where/How to send requested information Other: _____

☐ Emailed to: _____

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: _____ Name, signature of person requesting access and today's date. _____

Signature: _____ Date: _____

Requested by: (Check One)

☐ Patient ☐ Personal Representative (Documentation Attached)

☐ Parent ☐ Legal Guardian (Documentation Attached)

Include documentation of legal guardianship or Healthcare Power of Attorney ***if*** the person requesting access is not the patient or custodial parent.