This form permits the release of information for requests made by the patient.

Patient's Request to Access Protected Health Information ("PHI")

Anderson Healthcare

Internal Use Only

Visit #:_____M#:_____

Request #:_____ Pg. Count: _____

Photo ID Verified: ☐ Yes ☐ No Processed by_____ (initials)

PHI to be disclosed from:

Anderson Hospital - HIM
6800 State Route 162
Maryville, IL 62062

Return Completed form by mailing to the address on the left, fax to **618-288-0024**, or email to healthinformation@andersonhospital.org, or drop off in person.

Patient's Name:_____ **Date of Birth**_____

Patient's Address/Phone: _____

I request PHI to be disclosed to:

☐ Myself/Patient ☐ To the following person/entity: _____

Date(s) of service of PHI to be disclosed: From Date: _____ To Date: _____

Please specify PHI to be disclosed:

☐ Abstract (excludes consents, nursing notes, progress notes, physician orders, and MAR)
☐ History & Physical
☐ Consultation Reports
☐ Operative Reports
☐ Cardiology Reports
☐ Laboratory Reports
☐ Pathology Reports
☐ Discharge Summary / Final Diagnosis
☐ EKG
☐ Emergency Report
☐ Imaging Reports
☐ Imaging Disc
☐ Pulmonary Report
☐ Progress Notes
☐ Physician Orders
☐ Complete Medical Record
☐ Sleep Study
☐ Medication Administration Record (MAR)
☐ Other (specify):

_____

_____

I request that PHI be provided in the following format (if readily reproducible in this format):

☐ Paper Copy ☐ Mailed (to address below) ☐ Unsecure Fax (to fax number below)

☐ CD (UNENCRYPTED/ENCRYPTED, ***circle one***) ☐ E-Mail (to e-mail address below) (UNENCRYPTED/ENCRYPTED, ***circle one***)

I request that access to PHI be provided by the following method:

☐ Personal pick-up or inspection

☐ Mailed to the following address: _____

☐ Emailed to the following e-mail address: _____

☐ Faxed (unsecure) to: _____

☐ Other (specify) : _____

I agree to receiving copies of PHI through unencrypted methods such as, CDs, faxes, or emails from Anderson Healthcare or its Affiliated Covered Entities at the email address or fax number provided by me to Anderson Healthcare as indicated on this request. I understand that these means of communication may be unsecure and could potentially be intercepted and seen by others. By signing this request, I acknowledge and accept these risks and choose to receive unencrypted copies of PHI. 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 copies of PHI I requested.

_____
Printed Name

_____ _____ _____
Signature of Patient or Personal Representative Date Time

Requested by: (Check One)

☐ Patient ☐ Personal Representative (Documentation Attached)
☐ Parent ☐ Legal Guardian (Documentation Attached)