Hendricks Regional Health

# REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION



**NOTE: This form is used when patients or personal representatives are requesting access to their own health information or the information of the person to whom they are a personal representative or want to request that such information be sent to a designated third party. If you wish to authorize Hendricks Regional Health to disclose information about the identified patient to a third party at the third party's request, please use *Form #8014 Authorization For The Use Or Disclosure of Health Information*.**

Date: _____ Account # (if known): _____

Patient Name: _____ AKA/Other Names: _____

Date of Birth: _____ Phone: _____

Address: _____ City/State/Zip: _____

Email (optional): _____

You have requested access to health information about yourself/the patient identified above. To enable us to process your request, please read the following carefully and complete the requested information below.

**There may be fees associated with your request.** The form and manner in which you access your information may determine the amount of such fees. Fees will be due upon your receipt of the requested information. If you have questions or would like an estimate of fees in advance, please contact us.

You would like access to the health information maintained by Hendricks Regional Health as follows: *(Check one)*
- ❑ Inspect only
- ❑ Copy only
- ❑ Inspect and copy

You may obtain the following in lieu of a copy of the medical records:
- ❑ Written summary of health information

If requesting a copy or written summary, you would like it sent to:
- ❑ Patient/Self (at the contact information provided above)
- ❑ Personal Representative/Self (as indicated below)
- ❑ Designated Third Party (as indicated below)

Recipient Name: _____

Recipient Address: _____

City/State/Zip: _____

Recipient Phone: _____

Recipient Fax: _____

Recipient Email (if applicable): _____

Manner of Delivery for copy or written summary:

- ❑ Paper
  - ❑ Mail Delivery
  - ❑ In-Person Pickup
- ❑ Electronic (e.g., email, USB, CD, Portal, Fax Other)

Please specify: _____
If requesting electronic access in a manner that is unencrypted or otherwise unsecure, we will contact you to discuss the potential risks of such access.

Tell us which type of health information you want to access *(Check all that apply.)*

- ❑ Complete Health Record(s)
- ❑ Discharge Summary
- ❑ History and Physical
- ❑ Consultation Reports
- ❑ Billing Records
- ❑ Emergency Room Records
- ❑ Progress Notes
- ❑ Laboratory Tests
- ❑ X-ray Reports
- ❑ Other *(please specify)* _____

Covering the following period of time or dates of service: _____

The following classes of information are protected by special privacy laws and access may be subject to special rules or may be restricted under certain circumstances or access may require consultation with your physician or healthcare provider responsible for your care before release. If you are requesting access to records relating to any of the following, please initial each applicable item to confirm your request.

_____ Mental Health records
Initial

_____ Substance Use Disorder records
Initial

_____ Communicable Disease Records (including HIV/AIDS)
Initial

All patients' (or personal representative's) request(s) for access to their health information are processed in the order received and within the time frames required by law. Upon Hendricks Regional Health's receipt and review of your request, we will contact you to discuss when, where and how you may inspect and/or obtain a copy of the records requested and any related fees.

**I have read and confirm the terms of access stated herein.**

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|---|---|
| Patient or Personal Representative's Signature | Date |
| Print Name if Other Than Patient | Telephone # |
| Relationship to Patient of Personal Representative | ID Presented |
| Name of Hendricks Regional Health employee verifying signatory information | Title and Department |