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

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

Internal Use Only

Visit #:________________M#:_____________

Request #:______________ Pg. Count: ________

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

PHI to be disclosed from: ____
Entity Name & Address

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)