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

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

PHI Requested from:
Community Hospital of Staunton- HIM
400 North Caldwell Street
Staunton, IL 62088
Phone: 618-635-4258

Return completed form by mailing to the address on the left, fax to 618-635-4354, or email to
healthinformation@andersonhospital.org
forms can also be dropped 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 Requested: From Date: _____ To Date: _____

PHI to be released:

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

I request that PHI be provided in the following format (if readily reproducible in this 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 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 to _____

■ Other (specify) _____

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: _____

Signature: _____ Date: _____ Time: _____

Requested by: (Check One)

☐ Patient ☐ Personal Representative (Documentation Attached)

☐ Parent ☐ Legal Guardian (Documentation Attached)

Internal Use Only
Visit #: _____ M#: _____
Request #: _____ Pg. Count: _____
Photo ID Verified: ■ Yes ■ No
Processed by: _____