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: _____