REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

(To be used when patient wants to access their own medical record or allow a personal representative to do so.)

PATIENT NAME (PLEASE PRINT):	**Birth Date:**	**SS No.:** **(Last 4 digits only)**
	Drivers License No. (only required if you are NOT requesting records in person):	
	E-Mail Address:	

Information Being Released by:

Release Records To:	Address:	City:	
	Telephone No.:	State:	Zip:

Method of Disclosure: ☐ Paper ☐ Facsimile No:_____ ☐ Password Protected CD or DVD
☐ Portal (If choosing portal, please proceed to signature line. No other action needed.)
☐ Other:_____
☐E-mail address:_____
(Circle one) Secure/Encrypted or Unsecure/Unencrypted
Note if sending **unsecured/unencrypted** e-mail over the internet, there is some level of risk that the information could be read or otherwise accessed by a third party while in transit. Please initial here that you wish to send unencrypted:_____

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:

Dates of Treatment:	**Place of Treatment:** ☐ Inpatient ☐ Emergency Room ☐ Outpatient ☐ Other (specify):

Choose from the following for medical record copies (please initial beside documents):

_____	**All Dictated Reports**	_____	Lab (may include AIDS/HIV information)	_____	History & Physical
_____	**Radiology Reports**	_____	Pertinent Summary	_____	Discharge Summary
_____	**Pathology Reports**	_____	ER Record	_____	Consultation
_____	**Anesthesia Record**	_____	Billing Record	_____	Operative/Procedure Report
_____	Entire Chart	_____	Photographs/Images	_____	Other (specify):

I understand that:

1. I may revoke this request in writing at any time, but if I do so, it will not have any effect on any actions taken by the facility releasing the information (hereafter referred to as "the facility") prior to the facility's receiving the revocation.
2. This request allows the facility to release the above indicated documents in my medical record, including those copies from other health care facilities and providers as requested. The released information may no longer be protected by federal privacy regulations and may be redisclosed.
3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information, I hereby authorize the release of information. This also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.
4. The facility is hereby released from any liability and the undersigned will hold the facility harmless for complying with this request.
5. My signed (written) request will expire in ninety (90) days unless I provide an alternate expiration date or event. This request will not apply to any dates of service that occur after the date this request is signed. Patient Portal access will expire upon termination of Portal account.

I have read and understood the above statements. I hereby authorize the release, use, and disclosure of the above-requested protected health information about me.

Signature of Patient	Signature of Patient's Authorized Representative	
Date	Description of Representative's Authority to Act for Patient	Telephone Number