Mercy

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

I request my PHI from the following Mercy Facility: _____

Patient's Name: _____ **Patient's Date of Birth:** _____

Patient's Address: _____

Patient's Phone Number: _____

I request a copy of the following PHI: *(please check the boxes below)*

☐ Physician Office Notes	☐ X-ray Reports	☐ Mammogram Report
☐ Discharge Summary	☐ Laboratory Reports	☐ Physician Orders
☐ History/Physical	☐ EKG	☐ Emergency Department Record
☐ Consultation Reports	☐ Pathology Reports	☐ Billing Statements
☐ Operative Reports	☐ Progress Notes	☐ Abstract of Health Information
☐ X-Ray Images	☐ Radiology Images	☐ Other *(specify)*

Date(s) of Service of PHI Requested: From Date: _____ To Date: _____

(if dates are not specified, records will be provided for all dates of service)

IMPORTANT: If my record contains information regarding drug/alcohol abuse, mental health treatment, HIV/AIDS testing or treatment, genetic information, communicable diseases or other sensitive information I request that such information be included with my records: ☐ **Yes** *(include with my records)* ☐ **No** *(do not include with my records)*

I request that PHI specified above be provided:

☐ To me

☐ To the following person/entity: _____

(Specify name and address of person/entity to whom you would like your PHI to be sent)

I request that PHI be provided in the following format (if readily reproducible in this format):

☐ Paper Copy

☐ Electronic Copy via *(check below)*

☐ PDF Attachment to E-Mail ☐ CD ☐ Flash Drive

☐ Uploaded to MyMercy Web Portal ☐ Other: _____

I request that access to PHI be provided by the following method:

☐ Personal pick-up at above specified Mercy facility

☐ Inspection at above specified Mercy facility: *Requested Appointment Date/Time:* _____

(You will receive a call at above phone number to confirm this requested appointment)

☐ Mailed to the following address: _____

☐ Emailed by **Secure Mail** to the following e-mail address: _____

☐ Emailed by **Unsecure Mail** to the following e-mail address: _____

☐ Faxed to the following fax number: _____

☐ Available to me via MyMercy Web Portal

☐ Other: *(specify)* _____

ACKNOWLEDGMENT: I understand that the CD/Flash Drive is not secure and that I am responsible for protecting information on the CD/Flash Drive. I also understand that unsecure/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/Flash Drive or by unsecure 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.

Printed Name: _____

Signature: _____

Date: _____

Access Requested By: *(Check One)*

☐ Patient ☐ Parent (for minors) ☐ Personal Representative

If this request is signed by the patient's personal representative:
Please specify your authority to act on behalf of the patient and attach supporting documentation:

_____

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INTERNAL USE ONLY

Verification Via:

Photo ID: ☐ Yes ☐ No

Matching Signature: ☐ Yes ☐ No

Other: *(specify)* _____

Personal representative documentation provided and checked: ☐ Yes ☐ No

Request: ☐ Approved ☐ Denied (reason: _____)

Processed by: _____ Date: _____