

Jordan Valley Medical Center Patient Request to Inspect and/or Obtain a Copy of Protected Health Information

I desire access to and/or copies of medical information created and maintained by Jordan Valley Medical Center. I authorize Jordan Valley Medical Center to copy and/or disclose to me my health information.

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

PURPOSE FOR USE / DISCLOSURE

Approximate date(s) of service to be used/disclosed _____

INFORMATION TO BE USED / DISCLOSED

- | | | |
|---|---|--|
| <input type="checkbox"/> Consultation Report(s) | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> EKG Reports(s) |
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Operative/Procedure Report | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Radiology Reports/films |
| <input type="checkbox"/> Other _____ | | |

I understand that this information may include information relating to: Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV): treatment for drug or alcohol abuse; or mental or behavioral health or psychiatric care, excluding psychotherapy notes.

I desire access to my protected health information as follows:

- The information identified above should be sent to me at the following address:

_____ Address _____ City _____ State _____ Zip _____

- I would like to pick up the information noted above on the following dates and time:

_____ Date _____ Time _____

- I want to review my protected health information, but I do not need a copy. I would like to review the information noted above on the following date and time:

_____ Date _____ Time _____

I understand that Jordan Valley Medical Center may charge a fee for the cost of copying, mailing, or other supplies associated with this request (not to exceed the community standard), and such fees must be paid in advance.

I understand that Jordan Valley Medical Center may deny my request to inspect and obtain a copy of my protected health information in certain limited circumstances. I understand that if I am denied the opportunity to inspect and obtain a copy of my protected health information, I may request that the denial be reviewed in certain situations.

Signature of Patient or Patient's Representative

Printed Name of Patient or Patient's Representative

Relationship to Patient

Date

Daytime Telephone Number

	Account Number:	MR Number:
	Patient Name:	
	Admit Date:	

Jordan Valley
MEDICAL CENTER
3580 West 9000 South
West Jordan, UT 84088
(801) 561-8888

DOB	Age	Sex	HT	WT	RM-BD	PT	SVC	FC
Allergies:								
Attending Physician Name:								