

## Glenwood Regional 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 Glenwood Regional Medical Center. I authorize Glenwood Regional 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 Glenwood Regional 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 Glenwood Regional 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:	



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