

St. Joseph 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 St. Joseph Medical Center. I authorize St. Joseph 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 _____ | | |

In which form do you wish to receive a copy of your records?

- Paper
- Electronic (.pdf)
→ including the Continuity of Care Document

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:

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

Address _____ City _____ State _____ Zip _____

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

Date _____ Time _____

3 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 St. Joseph 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 St. Joseph 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
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Allergies: _____

Attending Physician Name: _____