

Salt Lake 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 Salt Lake Regional Medical Center. I authorize Salt Lake 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 Salt Lake 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 Salt Lake 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: _____



**Salt Lake Regional
MEDICAL CENTER**

1050 East South Temple - Salt Lake City - Utah 84102
(801) 350-4111

DOB	Age	Sex	HT	WT	RM-BD	PT	SVC	FC
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Allergies: _____

Attending Physician Name: _____