REQUEST TO INSPECT OR COPY HEALTH INFORMATION

Please submit this request to our Health Information Management Department. If you have any questions, comments or complaints, or would like to review or obtain a copy of our Notice of Privacy Practices, please contact:

Clara Barton Medical Center
HIM Department
250 West 9th Street
Hoisington, KS 67544
Telephone: (620) 653-5092 Fax: (620) 653-2671

PATIENT HEALTH INFORMATION REQUESTED:

Patient name:_____ Date of Birth: _____

Street Address: _____ City _____ State _____ Zip _____

Telephone: _____-_____-_____ Email: _____

RECORDS REQUESTED:

Please specify the records you wish to inspect or obtain copies of:

- ☐ UB (837-I)
- ☐ HCFA 1500 (837-P) or (837-D)
- ☐ Detail bill
- ☐ Advance directives
- ☐ Amendments
- ☐ Anesthesia records
- ☐ Assessments
- ☐ Care plan
- ☐ Consent for treatment forms
- ☐ Consultation reports
- ☐ Diagnostic study results (lab, radiology, pathology, etc)
- ☐ Discharge instructions
- ☐ Discharge/narrative summary
- ☐ E-mails containing patient-provider or provider-provider communication
- ☐ Emergency department record
- ☐ Graphic records
- ☐ Immunization record
- ☐ Intake/output records
- ☐ Medication records
- ☐ Multi-disciplinary progress notes/documentation
- ☐ Notes
- ☐ Operative and procedure reports
- ☐ Orders
- ☐ Patient-submitted correspondence, documentation
- ☐ Practice guidelines or protocols/clinical pathways that embed patient data
- ☐ Problem list
- ☐ Procedure reports
- ☐ Records of history and physical examination
- ☐ Treatment related correspondence
- ☐ Videos/photographs
- ☐ Therapy/rehabilitation records
- ☐ _____

Is an electronic copy requested? ___ Yes ___ No. If yes, designate format:(e.g., PDF, CCDA, image, picture, etc. for the information requested): _____

Please indicate method of delivery if copies are requested:

- ☐ I will pick up the records from the Hospital/Clinic.
- ☐ Fax my medical records to: _____.
- ☐ Please mail the records to my home address.
- ☐ Email my records to me. (must include email address and sign the consent to email (below)

CONSENT TO EMAIL

I request Clara Barton Medical Center and Clinics communicate with me or with another individual about me by email at _____. I understand that these communications will contain my protected health information, social information, my personal identification information (including demographic and financial information), and may include my social security number, date of birth, credit card or banking information. This information may not be encrypted when sent and may not be completely secured. I understand that the confidentiality of my information may not be completely secured.

I understand that electronic communications may be intercepted during transmission, may be misdirected or may be otherwise obtained by third parties. I accept these risks and any possible personal or financial harm which may occur as a result of electronic communications.

I also realize that my email may not actually be received, opened, read or responded to in a timely manner. If I rely upon email, I realize my condition could worsen before I get a response and that I could be harmed as a result of waiting for an email response. I knowingly accept this risk. I realize and hold hospital harmless from any injury I may incur as a result of email communications.

_____ _____

Signature of Patient or Patient's Personal Representative Date

AUTHORIZATION TO RELEASE RECORDS (If authorizing someone else to pick up records)

I, _____give permission for _____ to pick up a copy of my medical information.

I understand that my health information may contain information relating to: HIV, contagious diseases, psychiatric treatment, mental health treatment, substance abuse treatment, or other conditions which may be specifically protected by law and I authorize disclosure of that information, I understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations and may be redisclosed by the person receiving it.

I request access to the health information and records indicated on this form as set forth above. I certify that the records sought are my own or that I am the personal representative of the patient whose records are sought and am authorized to make this request.

_____ _____

Signature of Patient or Patient's Personal Representative Date

Personal Representative's Relationship to Patient: _____

I understand that I can revoke this authorization in writing but that any revocation is not effective for disclosures that have already been made. To revoke this authorization, I should contact: Clara Barton Medical Center HIM Department

Medical Record Number: _____ This form is valid from: _____/_____/_____ to _____/_____/____