Mercy

Patient's Request to Access Protected Health Information ("PHI")

I request my PHI from the following Mercy Facility: _____

Patient's Name: _____ **Patient's Date of Birth:** _____

Patient's Address: _____

Patient's Phone Number: _____ **Social Security # (Last 4 Digits):** _____

I request a copy of the following PHI: *(please check the boxes below)*

☐ Physician Office Notes	☐ X-Ray Reports	☐ Mammogram Report
☐ Discharge Summary	☐ Laboratory Reports	☐ Physician Orders
☐ History/Physical	☐ EKG	☐ Emergency Department Record
☐ Consultation Reports	☐ Pathology Reports	☐ Billing Statements
☐ Operative Reports	☐ Progress Notes	☐ Abstract of Health Information
☐ X-Ray Images	☐ Radiology Images	☐ Psychotherapy/SUD Counseling Notes
☐ Other *(specify)*		

Date(s) of Service of PHI Requested: From Date: _____ To Date: _____
(if dates are not specified, records will be provided for all dates of service)

IMPORTANT: If the PHI identified above includes information about substance use disorder, mental health, genetic information, sexually transmitted diseases, HIV/AIDS testing or treatment or any other sensitive information, by signing this Patient's Request to Access PHI form, I confirm that I am requesting access to this information, unless I otherwise specify in detail what is to be excluded here: _____

I request that PHI specified above be provided:

☐ To me

☐ To the following person/entity: _____
(Specify name and address of person/entity to whom you would like your PHI to be sent)

I request that PHI be provided in the following format (if readily reproducible in this format):

☐ Paper Copy

☐ Electronic Copy via *(check below)* ☐ PDF Attachment to E-Mail ☐ CD

☐ Uploaded to MyMercy Web Portal ☐ Other: _____

I request that access to PHI be provided by the following method:

☐ Personal pick-up at above specified Mercy facility by me

☐ Personal pick-up at above specified Mercy facility by
(specify name and relationship to patient): _____

☐ Inspection at above specified Mercy facility: *Requested Appointment Date/Time*: _____
(You will receive a call at above phone number to confirm this requested appointment)

☐ Mailed to the following address: _____

☐ E-Mailed by **Secure Mail** to the following e-mail address: _____

☐ E-Mailed by **Unsecure Mail** to the following e-mail address: _____

☐ Faxed to the following fax number: _____

☐ Available to me via MyMercy Web Portal

☐ Other: *(specify)* _____

ACKNOWLEDGMENT: I understand that the CD is not secure and that I am responsible for protecting information on the CD. I also understand that unsecure/unencrypted e-mail is not secure and while in transit it can be intercepted and seen by others. **By requesting to receive my PHI electronically on a CD or by unsecure e-mail I acknowledge that I understand and accept these risks.**

I understand that I may be charged a reasonable fee for the costs of labor for copying, postage, supplies as permitted by HIPAA Privacy Rule and state law. All request(s) for access to health information are processed in the order received and within the time frames required by law. Upon Mercy's receipt and review of your request, we may contact you to clarify the scope of your request or to discuss when, where and how you may inspect and/or obtain a copy of the records requested and any related fees. If you would like an estimate of the related fees to process this request, please contact us.

Printed Name: _____

Signature: _____

Date: _____

Access Requested By: *(Check One)*

☐ Patient ☐ Parent (for minors) ☐ Personal Representative

If this request is signed by the patient's personal representative:
Please specify your authority to act on behalf of the patient and attach supporting documentation:

_____

Acknowledgment of Personal Pick Up:

Records picked up by (name/signature)_____ Date:_____

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INTERNAL USE ONLY

Identity Verification:

Verification via Photo ID: ☐ Yes ☐ No

Verification via Matching Signature: ☐ Yes ☐ No

Other: *(specify)* _____

Authority Verification:

Personal representative documentation provided and checked: ☐ Yes ☐ No

Request: ☐ Approved ☐ Denied (reason: _____)

Processed by: _____ Date:_____