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	☐ 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 I am requesting contains information about drug/alcohol abuse, mental health treatment, 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 state 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: _____
☐ Emailed by **Secure Mail** to the following e-mail address: _____
☐ Emailed 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.

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: _____