COMMUNITY HOSPITAL
Advanced care. Always there.

Patient Identification Sticker
Goes Here

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Instructions:
Please complete this entire form to request inspection or copies of your personal health information maintained by Community Hospital. We will notify you when your request has been processed and the records are ready for inspection or have been copied. There are certain circumstances in which your request may be denied. If your request has been denied, you will be notified of the denial and the reasons why. Community Hospital cannot process your request if this form is not complete.

Patient Name: _____ Date of Birth: _____

Current Address: _____ Phone Number: _____

_____

Dates of service or time period of records requested: _____
(State a specific time period or "all")

Please check below the information which you would like to review (you may check more than one box):

☐ Medical Record
☐ Billing Record
☐ Other (be specific): _____

Please designate the method of review:

Mail
☐ Receive a copy by regular mail at the following address: _____

_____

_____

Inspection Only
☐ Inspect the information at Community Hospital. Information will be available at Health Information Management during normal business hours for inspection.

Inspection and Copy
☐ Inspect the information at Community Hospital and receive a copy at the time of inspection.

Electronic Copy
Format Request: ☐ PDF
☐ _____ (If other format requested, please specify.)

Media
☐ CD
☐ Transmitted to the following e-mail address: _____

I UNDERSTAND THE RISKS IN RECEIVING MY PROTECTED HEALTH INFORMATION VIA UNENCRYPTED E-MAIL AND THAT IT MAY BE READ BY A THIRD PARTY.

☐ Mailed on a USB drive to the following address: _____

_____

_____

☐ Other media request: _____

_____ _____
Signature of patient or patient's Personal Representative / Relationship to patient Date

OFFICE USE ONLY:

Records were released by: _____ Date: _____