Memorial COMMUNITY HEALTH

dba Memorial Health Clinics (Aurora, Clay Center, Harvard), Memorial Hospital, Memorial Community Care, East Park Villa

REQUEST FOR ACCESS TO OR RELEASE OF PROTECTED HEALTH INFORMATION

INSTRUCTIONS: PT MRN: _____

Please complete this form *to request inspection or copies of your health information. There are certain circumstances in which your request may be denied. If so, you will be notified of the reasons why. Please allow a minimum of 72 hours after the written requests are received for processing and up to 7-10 business days for all sent mailed requests. Medical record charge includes postage and handling flat fee of no more than $20.00 ($0.50 pg.) §71-8404. Individuals generally have access to their medical records during and after treatment via the Patient Portal. All medical records sent for continuity of care are complimentary. Encrypted emails are sent unless the email is requested to be unencrypted.*

PATIENT NAME: _____DOB:_____
ADDRESS: _____
PHONE NUMBER: _____ Email: _____

DATE(S) OF SERVICE REQUESTED _____

PLEASE CHECK BELOW THE INFORMATION, WHICH YOU WOULD LIKE RELEASED:

- ☐ Clinic visit notes
- ☐ Consultation report
- ☐ History & Physical exam
- ☐ Emergency room exam
- ☐ X-ray reports
- ☐ Radiology images
- ☐ Lab reports
- ☐ Discharge summary
- ☐ Financial record
- ☐ Other_____

PROHIBITION ON REDISCLOSURE OF DIAGNOSIS, TESTING AND/OR TREATMENTOF: Alcohol use, Drug use, HIV, sexually transmitted disease, Psychiatric disorders and/or mental health information. This information has been disclosed from records protected by federal law. 42CFR Part 2 prohibits any further disclosures of these records without a specific written authorization of the person to whom it pertains, or as otherwise permitted by law.

Purpose of Disclosure: ____ my request ____ Other_____

PLEASE INDICATE THE METHOD OF RELEASE:

Send a copy by U.S. mail to the following address:

_____
_____
_____

- ☐ Will pick up.
- ☐ Electronic: (USB,CD)
- ☐ Unencrypted Email: _____

Information will be available at MCHI during regular business hours (8:00 am- 5:00 pm Monday- Friday) unless other special arrangements are made. All other persons designated to pick up the Release requested must be submitted in writing with the Patient's Signature and date. Please include supporting documentation such as Power of Attorney or other documents establishing status as personal representative, when applicable. All medical information disclosed is no longer protected by State or Federal law. The patient may revoke this authorization in writing. This authorization is NOT VALID unless COMPLETED in FULL. I understand that my refusal to sign will not affect my ability to obtain treatment at MCHI. §71-8401-§71-8407

_____ _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE RELATION TO PATIENT

_____
WITNESS DATE

WE WILL NOT PROCESS THIS REQUEST UNLESS IT IS SIGNED BY YOU OR YOUR REPRESENTATIVE.

OFFICE USE ONLY:
Physician Approval: _____ Date sent: _____ Initials: _____