



REQUEST FOR ACCESS TO OR RELEASE OF PROTECTED HEALTH INFORMATION

INSTRUCTIONS:

Please complete this entire form to request inspection or copies of your personal health information maintained by MCHI. There are certain circumstances in which your request may be denied. If so, you will be notified of the reasons why. MCHI cannot process your request if this form is not complete. You will be notified of any fees that may apply.

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

PHONE NUMBER: _____

Dates of service or time period of records requested: _____

PLEASE CHECK BELOW THE INFORMATION WHICH YOU WOULD LIKE TO REVIEW OR RELEASE:

- | | | |
|--|--|---|
| <input type="checkbox"/> Clinic visit notes | <input type="checkbox"/> Consultation report | <input type="checkbox"/> X-ray reports |
| <input type="checkbox"/> History and physical exam | <input type="checkbox"/> Emergency room record | <input type="checkbox"/> Radiology images |
| <input type="checkbox"/> Lab reports | <input type="checkbox"/> Discharge summary | <input type="checkbox"/> After care plan |
| <input type="checkbox"/> Financial record | <input type="checkbox"/> Progress notes | |
| Other _____ | | |

Purpose of Disclosure: My request Other _____

PLEASE INDICATE THE METHOD OF RELEASE:

- Send a copy by regular mail to the following address

- Inspect the information at MCHI. Information will be available at MCHI during normal business hours (8:30 am to 4:00 pm Monday through Friday) unless other special arrangements are made.
- Inspect the information at MCHI and receive a copy at the time of inspection.
- Other method: _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

DATE

AUTHORITY OF PERSONAL REPRESENTATIVE

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