



St. Francis
Memorial
Hospital

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 St. Francis Memorial Hospital (SFMH). 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. SFMH cannot process your request if this form is not complete.

Patient Name: _____ D.O.B: _____

Current Address: _____

Phone No.: _____

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:

Receive copy by regular mail at the following address: _____

Receive an electronic copy to be electronically transmitted to the following e-mail address:

I UNDERSTAND I MUST CREATE A ZIX ACCOUNT TO RETRIEVE MY RECORDS ELECTRONICALLY.

Receive a copy by fax at the following fax number: _____

Inspect the information at SFMH. Information will be available in the Health Information Management Department during normal business hours for inspection.

Inspect the information at SFMH and receive a copy at the time of inspection. (Designate address above.)

Signature of patient or patient's personal representative

Date

Authority of personal representative

Witness Date/Time

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

