REQUEST TO INSPECT OR COPY HEALTH INFORMATION

Please submit this request to our Privacy Officer/Contact Person. If you have any questions, comments or complaints, or would like to review or obtain a copy of our Notice of Privacy Practices, please contact:

Jaime Gosselin
Privacy Officer
P.O. Box 389
Plainville, KS 67663
785-434-4553 x236

PATIENT HEALTH INFORMATION REQUESTED:

Patient name:____ Date(s) of Treatment:______________________________
Address: ____
Telephone: _____-_____-_____ Date of Birth: _____/_____/_____ Social Security Number:______-______-______

RECORDS REQUESTED:
Please specify the records you wish to inspect or obtain copies of (please include date(s) of treatment to help us process your request):

UB-92 (837-I) ____
HCFA 1500 (837-P) or (837-D) __________________________
Detail bill ____
Advance directives _____________________________________
Amendments ____
Anesthesia records ______________________________________
Assessments (i.e, nursing, MDS, OASIS, etc.) _______________
Care plan ____
Consent for treatment forms ______________________________
Consultation reports ____________________________________
Diagnostic study results (e.g., laboratory, radiology, pathology, etc.) ____
Discharge instructions ___________________________________
Discharge/narrative summary _____________________________
E-mail containing patient-provider or provider-provider communication ____
Emergency department record _____________________________
Graphic records ____
Immunization record _____________________________________
Intake/output records ____________________________________
Medication records ______________________________________
Multi-disciplinary progress notes/documentation ______________
Notes ____
Operative and procedure reports ___________________________
Orders ____
Patient-submitted correspondence, documentation ____________
Practice guidelines or protocols/clinical pathways that embed patient data ____
Problem list ____
Procedure reports ____
Records of history and physical examination ________________
Source data: ____
(a) analog and digital patient photographs for identification purposes only
(b) diagnostic films and other diagnostic images
(c) electrocardiogram tracings
(d) fetal monitoring strips
Therapy/rehabilitation records (i.e., occupational, physical, respiratory, speech) ___________________________________
Treatment related correspondence _________________________
Videos/photographs ____________________________________

Please specify the type of access you request (e.g., inspection or copying):____

Where may we contact you with questions about this request or to set up a time to inspect the records if requested (include address, phone number and best time to call): ____
____

Please indicate method of delivery if copies are requested:

I will pick up the records from the Hospital.
Please fax. My fax number is __________________.
Please mail the records to the following address (Please note that we can only send records to the patient whose medical information is being requested. All other requests must be made through an Authorization): ___________
____

I request access to the health information and records indicated on this form as set forth above. I certify that the records sought are my own or that I am the personal representative of the patient whose records are sought and am authorized to make this request.

____ ____________________________
Signature of Patient or Patient's Personal Representative **Date**

Personal Representative's Relationship to Patient:____

(PROVIDE THE PATIENT A COPY OF THIS FORM UPON COMPLETION)