ROOKS COUNTY
RCH
HEALTH CENTER

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:

LaDonna Shetterly
Privacy Officer
1210 N. Washington
Plainville, KS 67663
785−434−4553

PATIENT HEALTH INFORMATION REQUESTED:

Patient name: _____ Date(s) of Treatment: _____

Address: _____

Telephone: _____ Date of Birth: _____

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 call. My phone 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): _____

_____

Is an electronic copy requested? _____ yes _____ no

If yes, designate format _____

I request access to the health information and records indicated on this form as set forth above. I certify that the records sough 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	Relationship to Patient	Date/Time Signed

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