PHILLIPS COUNTY
HOSPITAL
Ranked Top 20 in The Nation's Critical Access Care Hospitals.

REQUEST TO INSPECT OR COPY HEALTH INFORMATION
PHOTO ID REQUIRED

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:

Donna Winchell, RHIT, Privacy Officer
Phillips County Hospital
1150 State Street, Phillipsburg, Ks
Telephone: 785-540-4921

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 (837-I)
____ Detail bill
____ Amendments
____ Consent for treatment forms
____ Laboratory records
____ Radiology records
____ Emergency department record
____ History and Physical
____ Medication records
____ Operative and procedure reports
____ Problem list
____ Photographs
(a) analog and digital patient photographs for identification purposes only
(b) diagnostic films and other diagnostic images
(c) electrocardiogram tracings

____ HCFA 1500 (837-P) or (837-D)
____ Advance directives
____ Anesthesia records
____ Consultation reports
____ Discharge instructions
____ Discharge/narrative summary
____ Immunization record
____ Intake/output records
____ Multi-disciplinary progress notes/documentation
____ Orders
____ Procedure reports

____ Therapy/rehabilitation records (i.e., occupational, physical, respiratory, speech) _____

Is an electronic copy requested? ___ Yes ___ No. If yes, designate format:(e.g., PDF, CCDA, image, picture, etc. for the information requested):_____

Please specify the type of access you are requesting (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): _____

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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):

_____

- ☐ Secure email to: (must sign consent to email (below):

_____

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: _____

CONSENT TO EMAIL

I request Phillips County Hospital communicate with me or with another individual about me by email at [email address]. I understand that these communications will contain my protected health information, social information, my personal identification information (including demographic and financial information), and may include my social security number, date of birth, credit card or banking information. This information may not be encrypted when sent and may not be completely secured. I understand that the confidentiality of my information may not be completely secured. I understand that electronic communications may be intercepted during transmission, may be misdirected or may be otherwise obtained by third parties. I accept these risks and any possible personal or financial harm which may occur as a result of electronic communications.

I also realize that my email may not actually be received, opened, read or responded to in a timely manner. If I rely upon email, I realize my condition could worsen before I get a response and that I could be harmed as a result of waiting for an email response. I knowingly accept this risk. I realize and hold hospital harmless from any injury I may incur as a result of email communications.

_____ _____

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

Personal Representative's Relationship to Patient: _____

RELEASE OF INFORMATION charges:

Paper _____ x 1¢/pg. = _____
Labor _____ x 30¢/min. = _____
Supplies (type) _____ = _____
Mode of delivery _____ pg. x _____ = _____
Printer _____ pg. x 2¢/pg. = _____
Color copy _____ pg. x 6¢/pg. = _____

TOTAL _____

Envelopes 4¢ each
9 x 3 Manilla 69¢ each
CD disc $6.50 each
postage to mail 49¢