PATIENT REQUEST TO ACCESS HEALTH INFORMATION

MR# ______________________ Date/Time Received: ______________

This form is ONLY used for patients (legal representatives) requesting their own health information

Patient Name: ______________________ **DOB:** ______________

Address: ______________________ **Telephone #:** ______________

From what location(s):

❑ HSHS St. Anthony's Memorial Hospital – Effingham ❑ HSHS St. John's Hospital – Springfield ❑ HSHS St. Joseph Hosptial – Highland
❑ HSHS St. Mary's Hospital – Decatur ❑ HSHS St. Elizabeth Hospital – O'Fallon ❑ HSHS Good Shephard Hospital – Shelbyville
❑ HSHS St. Francis Hospital – Litchfield ❑ HSHS St. Joseph Hosptal – Breese ❑ HSHS Holy Family Hospital– Greenville
❑ My Chart

From date(s) of service: _ _/_ _/_ _ to _ _/_ _/_ _ OR ______________

Type of Information:

❑ Abstract of record/Pertinent records	❑ History & physical	❑ Discharge summary
❑ Emergency Department report	❑ Consultation reports	❑ Operative reports
❑ Radiology/Imaging reports	❑ Laboratory/Pathology	❑ EKG
❑ Radiology/Imaging films/CD	❑ Progress notes__________	❑ Billing records __________

Or description of records and/or information as follows: ______________

Form of Information:

❑ Viewing –An appointment must be scheduled with our Release of Information Specialist telephone number __________
❑ Summary –You may request a summary of certain information instead of actual copies of records/information (for example, listing of all dates of service).
❑ Paper Copy of Record
❑ Electronic Copy of Records – MyChart, Email, CD, Portal, Other – Please specify: __________

Summary or Copy Requests: There may be a charge for the costs associated with preparing the summary or producing copies. You will be informed of these charges prior to processing the request.

Method of Delivery:

❑ Pick up/take along in person
❑ Mailed to address above
❑ Fax #: __________ By providing fax # I release the hospital from all liability for faxing my confidential information to this number.

❑ Email to: ______________ *If the e–email address isshared with another person or the e–mail password is known to others, consider other methods of delivery.* Wewill automatically send e–mail through encrypted/secured means unless otherwise directed. Unencrypted email poses some level of risk, e.g., a third party could see the information without consent. We are not responsible for unauthorized access to unencrypted email containing confidential information or any risk (e.g., virus) potentially introduced to the computer/device utilized when receiving/viewing confidential information in unencrypted electronic format or e–mail. By selecting the unencrypted e–mail option I acknowledge the risks have been communicated and I accept these risks. ❑ Unencrypted Email

Date __________ **Time** __________ **SIGNATURE by Patient or Legal Representative** ______________

OR document verbal request from Patient/Legal Representative Name ______________ **Received by (Colleague Name)** ______________

If by a Legal Representative, complete the following:

1) Individual is: ❑ a minor (AODA exception) ❑ legally incompetent or incapacitated ❑ deceased
2) Legal authority: ❑ parent ❑ legal guardian ❑ activated POA for Health Care ❑ next of kin/executor of deceased

OFFICE USE ONLY: Signature verified or Patient verified: ❑ Yes ❑ No Date/Time Released: ________ Completed by: ________

Original: Medical Record Copy: Patient A photocopy of this authorization will have the same force and effect as the original 1/31/18

C8711_066 PS# 10082038
New: 11/29/2019
12–27–2019 3:36:45 PM

RI

503 North Maple Street • Effingham, Illinois 62401