Patient Request to Access Medical Records Form

Request is hereby made for access to ❑ **Medical** ❑ **Dental** information regarding:

Patient Name: _____ Alias/Maiden Name_____

Date of Birth: _____Last 4 digits of Social Security Number: _____

Address: _____

City:_____State:_____Zip Code:_____

Home Phone: _____ Cell Phone:)_____

What type of access are you requesting? (*Check all that apply)*

❑ View	You will be notified within 10 days on how to schedule an appointment with our staff.
❑ Electronic Copy	You should receive notification within 30 days for completion. You may receive your records on a CD or USB Flash drive. (fees may apply)
❑ Paper Copy	You should receive notification within 30 days for completion. (fees may apply)

*Dates of Treatment: From_____ To _____

(Please Specify the Date of Service)

What information would you like to access?

❑ **Abstract of Medical Records for the dates of service specified above:** (specify date range above)
Physician, Psychiatric, Therapy Progress Notes, Consultation Reports, Procedure Reports, Pathology Reports, Laboratory Reports, Imaging Reports, Other diagnostic studies, Discharge Summary, Emergency Department Reports, and Immunization Record

Or: *(Select from the items below)*

❑ Laboratory Results	❑ Billing Statement	❑ Immunization Record	❑ Physician Progress Notes
❑ Consult Notes	❑ Imaging	❑ Discharge Summary	
❑ Dental Records	❑ Letter	❑ Medication/Problem List	

❑ Other _____

Outpatient Behavioral Health/Substance Abuse Treatment Records:

❑ Psychiatric Progress Notes ❑ Therapy Progress Notes ❑ Substance Abuse Treatment Notes

How would you like to obtain your records?

❑ My Chart Upload to MyChart (Email address): _____

❑ Pick up ❑ Mail records to above address ❑ Fax:_____

NOTE: If you want this information picked up at the office by **someone other than yourself**, please complete the information in this section.

Personal Representative Information:

Name: _____ Date of Birth:_____

Address: _____

City/State/Zip_____

Phone: _____Cell:_____

Relationship:_____

We are permitted by law to deny part or your entire request for access for one or more of the following reasons:

- Your access request form is not signed by you or your Personal Representative;
- Your access request form is signed by your Personal Representative and the Personal Representative has not provided information on the source of his/her authority to act for you;
- We do not maintain the information you have requested to copy or inspect;
- The information you have requested is not part of your records;
- Your request is for psychotherapy notes;
- Your request includes information compiled for litigation;
- A licensed health professional has determined that the requested access is likely to either endanger your life or safety or another person's life or safety or cause substantial harm to you or another person;
- Your request includes information not subject to access under the federal Privacy Act; or
- Your request relates to certain information that was obtained from a confidential source and we are not required to provide access to it by law.

Within the limitations of law, we will make every effort to accommodate your request.

All patients' (or personal representative's) request(s) for access to their health information are processed in the order received. Upon receipt by Keystone Health and review of your request, we will contact you for a time and place when and how you may inspect and/or obtain a copy of the records requested. As the HIPAA Privacy Rule mandates, we are required to provide you with access to your PHI within 30 days. In the event more time is required you will be notified.

This request for access will not require Keystone Health to provide health information about you to anyone other than to you or your personal representative. If you request us to disclose health records or information about you to some other person, we may need a signed authorization (a different form) from you to enable us to transmit such information.

I have read and confirm the terms of access stated herein.

_____ _____

Signature of Patient (A minor's signature (ages 14-17) **is required for the following records: HIV related information, sexually related treatment, mental health care or substance abuse treatment.**

Date

_____ _____

Signature of Parent, Legal Guardian, or authorized representative

Date

Please mail this form to:

Keystone Health
HIM- Release of Information Department
111 Chambers Hill Drive, Suite 200
Chambersburg, PA 17201
Phone Number: (717) 709-7960 Fax Number: (717) 217-1937
Email: khc-him@keystonehealth.org

**********Office Use Only**********

Received by:_____ Date:_____ Site:_____

Completed by:_____ Date:_____