Manhattan Surgical HOSPITAL

1829 College Avenue
Manhattan, KS 66502

REQUEST TO ACCESS AND COPY PROTECTED HEALTH INFORMATION FORM

Patient First Name: _____ Last Name: _____
Date of Birth: _____ Phone: _____E-mail Address (Optional): _____
Address: _____City: _____State: _____ Zip Code: _____

What records do you want? (Check appropriate boxes below):

☐Complete Medical Record (all notes, results, and discrete data elements)
OR

☐Billing Records	☐Operative Report
☐Discharge Summary	☐Nurses' Notes
☐History and Physical	☐Physician Orders
☐Imaging/Radiology Reports	☐Physician Progress Notes
☐Radiology film/tracing/media – provided on CD	☐Other/Outside records (please specify): _____
☐Lab Reports	_____

What dates of records would you like?

☐Specific dates(s): _____to _____**OR |** ☐All dates of encounters/visits.

If *you ARE NOT* receiving your own records, who will be receiving your records?

☐Health Care Provider ☐Insurance ☐School ☐Employer ☐Other: _____

Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____ Fax Number: _____
E-mail Address (if applicable): _____

If you would like us to send your records via email, we will send them securely encrypted. If you would like your records sent without encryption, there are risks that the message could be intercepted by an unintended recipient. By checking this box, you are requesting we send your records unencrypted and acknowledge these risks.

☐ **Send my records via unsecure, unencrypted email.**

If *you ARE* receiving your own records, how should they be delivered to you?

Choose <u>One</u> Option

☐ 1. **Mail**

We will use the address you list above, unless you provide a different address here:

Name: _____
Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____

☐ 2. **Pick Up**

In-Person By (name of person picking up your records): _____

☐ 3. **Electronic**

☐ Patient Portal ☐ **Email Address: _____**

If you would like us to send your records via email, we will send them securely encrypted. If you would like your records sent without encryption, there are risks that the message could be intercepted by an unintended recipient. By checking this box, you are requesting we send your records unencrypted and acknowledge these risks. ☐ **Send my records via unsecure, unencrypted email.**

I understand that:

- Requests for copies of medical records and/or non-document material may be subject to copying fees.
- Medical record information may include records related to mental health care, communicable diseases, HIV/AIDS, genetic testing, and/or alcohol drug/abuse. I authorize the release of these records.
- Manhattan Surgical Hospital is not responsible for a third party's unauthorized access to my personal health information delivered in this format or any risks (e.g., virus) potentially introduced to my computer/device when receiving personal health information through unsecure email.
- Protected health information provided on portable electronic media may not be encrypted and may be at risk for inadvertent disclosure if you lose the media or it is stolen. By requesting the use of portable electronic media, you accept this risk.

If you just wish to review your information and do not want information copied or reproduced, initial here _____.

If signed by a patient-authorized representative, supporting legal documentation must accompany this form.

Patient/Authorized Representative Signature_____
Date: _____ Time: _____

Printed Name of Authorized Representative: _____
Relationship to Patient: _____

Send completed form to:

Manhattan Surgical Hospital, LLC – Health Information Management
1829 College Avenue
Manhattan, Kansas 66502

Department Use Only: ☐ Identity/ Authority Verified by:

_____ (name or initials) Date: _____ Time: _____