Harlan County Health System
717 North Brown,
P.O. Box 836 Alma, NE 68920-0836
Phone (308)928-2151
Fax (308)928-2118

# *REQUEST FOR ACCESS TO PROTECTED 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:

Health Information Management
717 Brown PO Box 836
Alma, NE 68920
308-928-2151 (p)
308-928-2118 (f)

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**PATIENT HEALTH INFORMATION REQUESTED:**

Patient name:_____ Date(s) of Treatment: _____
Address: _____
Telephone: _____-_____-_____ Date of Birth: _____/_____/_____

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**RECORDS REQUESTED:**

Please specify the records you wish to inspect or obtain copies of:

☐ Financial Record
☐ Entire Medical Record
☐ Discharge Summary
☐ Emergency department record
☐ Immunization record
☐ EKG/ECG Result
☐ Progress Notes
☐ Medication Record
☐ Lab/Pathology Report
☐ Radiology Report
☐ Imaging CD
☐ Procedure Report
☐ Therapy/rehabilitation records (i.e., occupational, physical, speech) _____
☐ Other _____
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): _____
_____

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):
  _____
- ☐ Email to: (must sign consent to email (below): _____

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**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: _____

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**CONSENT TO EMAIL**

**I request Harlan County Health System 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: _____

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