SMITH COUNTY
MEMORIAL HOSPITAL

REQUEST TO INSPECT OR OBTAIN COPY OF HEALTH INFORMATION

COPY OF PHOTO ID REQUIRED FOR EACH REQUEST

EMAIL COMPLETED FORM TO HIM@scmhks.org

PATIENT HEALTH INFORMATION REQUESTED:

Patient Name: _____

Address: _____

Telephone: __ _-_____-_____ Date of Birth: _____/_____/_____

DATE(S) OF TREATMENT: _____

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):

- ☐ Billing Records _____
- ☐ Hospital Medical Records _____
- ☐ Radiology Images_____
- ☐ Family Practice Records_____

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

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:

- ☐ Patient Portal.
- ☐ I will pick up the records from the Facility.
- ☐ I authorize the following individual to pick up the records from the Facility on my behalf:

  _____ _____

  Name Relationship to patient

  I authorize Facility to release my records to the individual identified above. I have authorized this individual to pick up a copy of my records from Facility on my behalf. I understand that these records will contain my protected health information, social information, personal identification information (including demographic and financial information), and may include my social security number, date of birth, credit card or banking information. I further understand that Facility has no control over the records once they are released to this individual. The records could be lost, stolen, or viewed by the individual. I accept these risks and any personal or financial harm which may occur as a result of the individual picking up my records.

- ☐ Please fax. My fax number is _____.
- ☐ Please mail the records to the following address: _____.
- ☐ Please email to: _____ . Facility please transmit via (please check one of the following)

  ☐ Encrypted or ☐ Unencrypted email

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I understand that I have the right to receive emails from Facility in an unencrypted format. These communications will contain my protected health information, social information, personal identification information (including demographic and financial information), and may include my social security number, date of birth, credit card or banking information. 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 my request for unencrypted 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 Facility harmless from any injury I may incur as a result of email communications.

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:_____

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

FOR OFFICE USE ONLY

Request Received by: _____ Date: _____

Request Fulfilled by: _____ Date: _____

Request Delivered by: _____ Date: _____