Aspen Mountain Medical Center

PATIENT REQUEST TO ACCESS AND COPY HEALTH INFORMATION

Patient Name:			Date of Birth:
Patient Address:			
City:	State:		Zip Code:
Home Phone: (Provide direct number where you can be reached regarding this form or where a voicemail message may be left for you)			Cell / Other Phone:

Describe what specific records may be disclosed / check all that apply:

- ☐ All Records of treatment
- ☐ Billing Records, statements for services
- ☐ Nursing Notes, documentation
- ☐ Operative or Procedure Notes
- ☐ Physician notes, orders, history & physical
- ☐ Records from (date) __________________________ to (date) ___________________________
- ☐ Lab / diagnostic / test results only
- ☐ Imaging / Radiology Reports
- ☐ Discharge Summary
- ☐ Other records / please specify: ____

If you wish to receive an explanation or summary of your protected health information, initial here: __________.

Describe the format you would like your health information :

- ☐ Electronic
- ☐ Media
- ☐ Paper copies

Manner in which you would like delivered:

- ☐ Mail
- ☐ Email____
- ☐ Pick-up

If you want to receive your protected health information via unencrypted email, please provide the email address in the space provided above. **NOTE UNENCRYPTED EMAIL MAY BE AT RISK FOR INADVERTENT DISCLOSURE. BY PROVIDING YOUR EMAIL ADDRESS, YOU ACCEPT THIS RISK**.

If you want us to send the information to a third party, please provide the following information: the designated third party and where to send the protected health information.

Name: ____

Address: ____ Phone: _______________ Fax: _______________

City: ____ State: _________ Zip: _________________________

Please complete more than one form if multiple disclosures to multiple providers is requested.

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

I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative

____ ____

Signature of Patient or Personal Representative Date Time Relationship of Personal Representative

For Facility's Use

Request for Access Received: ____________________

If patient or personal representative unable to complete form, please provide the name of the facility staff member who completed the form: ____.

Date Access Provided: __________________________

On-site: _________

Email: __________

Paper: __________

Other electronic media: _________

Date Acknowledgment Sent: _____________________

Deadline to Respond: _____________________

Deadline Extended: ☐ No

☐ Yes Reason: ____

Date written notification given: _________________________

New deadline to respond: ______________________________

Date Denial: __________________ Reason: ____

____ _________________________

Signature of Privacy Officer/Designee Date