

# NEMAHA COUNTY HOSPITAL

## REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

**INSTRUCTIONS**

*Please complete this entire form to request inspection or copies of your personal health information maintained by NCH. We will notify you when your request has been processed and the records are ready for inspection or have been copied and the fee for your request. There are certain circumstances in which your request may be denied. If your request has been denied, you will be notified of the denial and the reasons why. NCH cannot process your request if this form is not complete.*

Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Current Address: \_\_\_\_\_

Phone No.: \_\_\_\_\_ MR#: \_\_\_\_\_

**Dates of service or time period of records requested:** \_\_\_\_\_

**Reason for Request:**

	Continued medical care Dr. _____ appt date _____
	Personal Health Record/my own copy
	Legal Reasons Attorney: _____
	Work-related reasons
	Disability Application
	Other: _____

**Please check the boxes of the information which you would like to review/receive copies of:**

<input type="checkbox"/> History & Physical	<input type="checkbox"/> Emergency Room Record
<input type="checkbox"/> Nursing Progress Notes	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Lab Reports	
<input type="checkbox"/> X-ray Reports	<input type="checkbox"/> Diagnostic Images (Films)
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Consultation Report	
<input type="checkbox"/> Itemized Statement of charges	<input type="checkbox"/> Complete record

**Please designate the method of review:**

Receive copy by regular mail at the following address: \_\_\_\_\_  
 I understand that I will be charged a per page copying fee of \$ .50. The first 10 pages are free. \_\_\_\_\_

Fax to Dr. \_\_\_\_\_ at (\_\_\_\_) \_\_\_\_\_.

Inspect the information at NCH. The Health Information Services Department will contact you when the records are ready for inspection.

Inspect the information at NCH and receive a copy at the time of inspection. (Designate address above.) I understand I will be charged a per page copying fee of \$ .50. The first 10 pages are free.

\_\_\_\_\_  
 Signature of patient or patient's personal representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Authority of personal representative

**WE WILL NOT PROCESS THIS REQUEST UNLESS IT IS SIGNED BY YOU OR YOUR REPRESENTATIVE**