Hamilton County Health Department

PATIENT REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

PERSON COMPLETING THE REQUEST: {} Patient { } Authorized Representative { } Provider

REQUEST RECEIVED VIA: { } Phone { } Fax { } Walk-In {} E-Mail PERSON NEEDING ACCESS TO PHI: { } Patient { } Authorized Representative { } Provider

REQUEST TYPE: { } Paper or Electronic copy (Complete Sections 1-3) { } My Electronic Health Records/Patient Portal (Section1&4)

SECTION 1: PATIENT INFORMATION (Required for All Requests)

Name:			Date of Birth:
Address:			Phone Number: ( ) -
City:	State:	Zip:	E-Mail:

SECTION 2: HEALTH INFORMATION REQEUSTED (Paper or Electronic copy ONLY)

{ } Abstract { } Labs	{ } Substance Abuse
{ } Complete Medical Record	{ } Sexually Transmitted Disease
{ } Immunization Records Only	{ } Family Planning/Contraceptive
{ } HIV/AIDS	{ } Mental Health

Dates of Service Requested (if needed):_____ Expiration Date:_____ or six months from date patient or authorization representative signs request for Medical Records form. I understand that I have the right to revoke this request form at any time in writing to Hamilton County Health Department, however, such a revocation will not be retroactive and any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. Notice of Privacy Practices also states that by Privacy law you have the right to revoke- S164.520

Purpose of Request: { } Continuation of Care { } Specialist { } Personal Use {} Other_____

Requested Delivery Method: { } Pick-Up { } Mail {} Fax Record Format: { } Paper { } Electronic Copy

SECTION 3: PERSON/ENTITY TO RECEIVE COPY OF MEDICAL RECORDS (Paper or Electronic Copy ONLY)

Name:	Phone Number: ( ) -		
Address:	City:	State:	Zip
E-Mail Address:	Fax Number: ( ) -		
Relationship to Patient: { } Parent { } Spouse { } Legal Representative { } Power of Attorney { } Other			
Signature of Patient/Authorized Representative: Date:			

Information Released From:	Fax: ( ) -
Address:	Phone: ( ) -

SECTION 4: COMPLETED FOR PATIENT'S AUTHORIZED REPRESENTATIVE (Patient Portal Access ONLY)

Name of Authorized Representative:	Phone Number: ( ) -
E-Mail Address:	Secondary E-Mail:
Relationship to Patient:	{ } Parent { } Spouse { } Legal Guardian/Representative { } Other

PATIENT- I understand that: Use of the patient portal Authorized Representative is voluntary and I am not required to grant another person access to my Electronic Health Records Patient Portal Account in this manner. By signing this document, I am acknowledging that I have read and understand the information above and I am granting this proxy to have access to my personal health information in the form of an Authorized Representative Portal Account. I may terminate this Authorized Representatives access to my Electronic Health Records patient portal any time by contacting Hamilton County Health department's Health Information Management Department personnel.

Patient Signature for Patient Portal:	Date:

Authorized Representative- I understand that: This Authorized Representative access is intended as secure online access to this patient's personal health information. I may not share its login information with another person. Access to Electronic Health records patient portal is proved as a convenience to patient/Client's and their Authorized Representatives. Hamilton County Health Department has the right to revoke access to the Patient Portal by a patient or their Authorized Representative at any time for any reason. It is my responsibility to make sure e-mail address is current. I understand if my e-mail is not current, I will not receive notifications sent to me about this patient/client. If the patient is not available to authorize my use of their patient portal, I understand that any documents related to my authority as Authorized Representative for the patient/client must be provided to Hamilton County Health Department prior to obtaining access to Patient Portal. By signing below, I attest that I have the authority to request and view this patient/client's Electronic Health Records.

Authorized Representative Signature for Patient Portal:	Date:

HEALTH INFORMATION MANAGEMENT PERSONNEL ONLY

Completed by (HIM Personnel Only for Phone/Verbal Requests:	Date: