REQUEST FOR PATIENT DIRECTED ACCESS TO PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION

Printed Patient's Name _____ Phone (_____)_____-_____

Patient's Birthdate _____ Social Security Number (last 4 digits) _____

DESCRIPTION OF MEDICAL RECORDS REQUESTED

Please select facility from which you are requesting records:

☐ Diley Ridge Medical Center ☐ Other _____

List Date(s) of Treatment _____

_____

_____

Please select documents:

☐ Emergency Department Records ☐ Discharge Summary ☐ History and Physical
☐ Consultations ☐ Operative Report ☐ Pathology
☐ Progress Notes ☐ Test Results (lab, radiology, EKG, EEG, echo)
☐ Other (list) _____

RECIPIENT OF THE MEDICAL RECORDS:

I direct the medical records indicated above to be provided to the following:

Name _____

Address _____

FORMAT REQUESTED:(check only one option)

☐ Paper ☐ CD ☐ Email If you choose email, insert email address and choose secured or unsecured below

Email address _____

☐ secured/encrypted email ☐ unsecured/unencrypted email *

*If you checked "unsecured email" please be aware there is some level of risk that your medical information could be read or otherwise accessed by a third party while in transit. By signing below you have accepted this risk and still want your medical information sent by unencrypted email.

**If records are unable to be emailed due to size limitations, please select an alternative format: ☐ Paper or ☐ CD.

SIGN HERE _____

Signature of Patient or Personal Representative Date

Printed name of patient's Personal Representative, if applicable _____

Describe Relationship to patient (e.g. minor's parent, guardian) _____

Personal Representative's Drivers Lincense Number _____

Mail request form to:
Mount Carmel St. Ann's, 495 Cooper Road, Suite 200, Westerville, OH 43081 (614-898-4075)

Diley Ridge Medical Center, Canal Winchester, Ohio

Request for Patient Directed Access to PHI

DRMC HIM 114-5-17

NAME

DOB

MR #

FIN #