Kearny County Hospital

500 E THORPE
LAKIN, KS 67860

REQUEST TO INSPECT OR COPY HEALTH INFORMATION

Please submit this request to our Privacy Officer/Contact Person. If you have any questions, comments or complaints, or would like to review or obtain a copy of our Notice of Privacy Practices, please contact:

TONY SALCIDO
Privacy Officer/ Contact Person
(620) 355-7111 ext. 1533

PATIENT HEALTH INFORMATION REQUESTED:

Patient name:____ Date(s) of Treatment: _______________

Address: ____

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

RECORDS REQUESTED:

Please check all the records that apply in order to specify the records you wish to inspect or obtain copies of:

☐ UB (837-I)
☐ **Detail bill**
☐ Amendments
☐ Assessments (i.e., nursing, MDS, OASIS, etc.)
☐ **Consent for treatment forms**
☐ **Diagnostic study results (e.g., laboratory, radiology, Pathology, etc.)**
☐ E-mail containing patient-provider or provider-provider Communication
☐ Immunization records
☐ **Medication records**
☐ Notes
☐ **Orders**
☐ Practice guidelines or protocols/clinical pathways that embed patient data
☐ **Records of history and physical examination**
☐ Source data:
(a) Analog and digital patient photographs for identification purposes only
(b) Diagnostic films and other diagnostic images
(c) Electrocardiogram tracings
(d) Fetal monitoring strips

☐ HCFA 1500 (837-P) or (837-D)
☐ **Advance directives**
☐ **Anesthesia records**
☐ **Care plan**
☐ **Consultation reports**
☐ **Discharge instructions**
☐ **Discharge/Narrative summary**
☐ **Emergency department record**
☐ Graphic records
☐ Intake/output records
☐ Multi-disciplinary progress notes/documentation
☐ **Operative and procedure reports**
☐ Patient-submitted correspondence, documentation
☐ Problem list
☐ **Procedure reports**
☐ Treatment related correspondence
☐ Videos/**Photographs**

☐ Therapy/rehabilitation records (i.e., occupational, physical, respiratory, speech) ______________________________

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

Please specify the type of access you are requesting (e.g., inspection or copying):______________________________

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:

- ☐ I will pick up the records from the Hospital.
- ☐ Please fax. My fax number is _________________.
- ☐ Please mail the records to the following address (Please note that we can only send records to the patient whose medical
- ☐ information is being requested. All other requests must be made through an Authorization):

____

____

- ☐ Email to: (must sign consent to email (below):____

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: ____

<u>CONSENT TO EMAIL</u>

I request [Hospital] communicate with me or with another individual about me by email at [email address]. I understand that these communications will contain my protected health information, social information, my personal identification information (including demographic and financial information), and may include my social security number, date of birth, credit card or banking information. This information may not be encrypted when sent and may not be completely secured. I understand that the confidentiality of my information may not be completely secured. 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 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 hospital harmless from any injury I may incur as a result of email communications.

____ ________________

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)