REQUEST FOR ACCESS
OHIO COUNTY HOSPITAL CORPORATION

This form is used to request access to your health information or to direct us to send it to someone else.

1. Who is the patient?

Name _____ Date of Birth _____
Mailing Address _____
_____ Phone number _____
SSN _____ MR # _____ Acct # _____

2. To what information would you like access?

☐ All health information (medical and billing records and other records used to make decisions about me) for all visits for the location(s) checked below
☐ Radiology reports / CD
☐ Laboratory results
☐ Emergency Room visits
☐ Discharge Summary
☐ History and Physical
☐ Consultation Reports
☐ Operative Reports
☐ Pathology Reports
☐ Only the records beginning from (date): _____ to (date): _____
☐ Other (please describe): _____

3. From what locations are you requesting information?

☐ All locations

OR choose one or more locations from the list below:

☐ Ohio County Hospital
☐ Ohio County Family Care ___ Hartford / ___ Beaver Dam
☐ Ohio County Specialty Clinic
☐ Quick Care
☐ Dr. Charles W. Riccio
☐ Ohio County Pain Care
☐ Fordsville Area Medical Clinic
Butler County Family Care
☐ Hospice of Ohio County

4. How would you like to receive the records? Please check if you would prefer:

___Paper ___CD __USB (thumb or flash) drive ___Patient portal

___Faxed – (please enter facsimile number - _____) **Please read and initial** if you acknowledge and accept the risk that this might be an unsecure method of delivery and that the records may be intercepted while being sent or received _____

___Encrypted email – please enter your email address: _____

___ Unencrypted email - **Please read and initial** if you acknowledge and accept the risk that this is an unsecure method of delivery and that the records may be intercepted while being sent and enter your email address above.

If not emailed, faxed, or delivered via patient portal, records will be:

☐ Reviewed and/or picked up by you in person.

☐ Picked up by someone you choose. If yes, who? (Please enter full name of person who will pick up and please let them know to bring a picture ID) _____

☐ Mailed to your home (address same as on page 1)

☐ Mailed to you at another location? If yes, please fill in the address. _____

_____

☐ Mailed/emailed to someone else at another location? If yes, please fill in the name and address. _____

_____

5. Please read and initial that you understand the important information below. _____

- I understand that the records that are released may contain reference to: **Alcohol/drug abuse information, mental health information, HIV/AIDs test results, genetic information and sexually transmitted diseases.**

Signature _____ Date _____
Patient or Legal Representative (Proof of identity/representation required)

Relationship, if not patient _____ Witness _____

Office use only
Identity verified via: ✓ Photo ID ✓ Other Specify _____

PHI mailed / faxed / e-mailed (circle) by _____ on _____ (date).