Patient Name:
DOB:
MR#:

Treasure Valley Hospital Individual Request for Access to Protected Health Information

As provided by the Health Insurance Portability and Accountability Act (HIPAA) you in most cases, have a right to inspect and obtain a copy of your health information contained in your medical record.

Requestors Name (Please Print):_____ DOB: _____

Phone Number: _____

Please indicate specifically the information to which you are requesting access:

- ☐ History & Physical
- ☐ Operative Report(s)
- ☐ Discharge Summary
- ☐ Progress Reports
- ☐ Physician Orders
- ☐ Pathology Report
- ☐ Lab
- ☐ Radiology Report
- ☐ Radiology Images (Provided on DISC)
- ☐ P.T.
- ☐ Billing
- ☐ Other_____

The purpose of this request is for:

- ☐ Further medical care
- ☐ Payment of insurance claim
- ☐ Worker's Compensation
- ☐ Legal investigation for: _____
- ☐ Other_____
- ☐ Disability
- ☐ Government agency

In accordance with Federal Regulations 42 CRF Part 2, I hereby consent to the release of records pertaining to the following:

- ☐ Conditions Related to Drug and/or alcohol Abuse
- ☐ Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Communicable diseases
- ☐ Conditions related to psychiatric treatment

Please indicate the means by which you wish to obtain a copy of the requested information:

- ☐ E-Mail Address_____
- ☐ Fax Number_____
- ☐ Mailing Address_____
- ☐ Onsite Pick Up

☐ I hereby authorize Treasure Valley Hospital to release information from my medical record
TO:_____
Person/Organization/Agency

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Authorized Person **Relationship to Patient**

*In case of a patient who is physically unable to sign this authorization, he/she should place an "X" on the signature line and have his/her assent witnessed.
*I understand that I may revoke this release of information at any time by notifying Treasure Valley Hospital in writing, but if I do, it will not have any affect on any actions taken before receiving the revocation.
*I understand that I can obtain a copy of this form after I sign it.
*I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by the privacy rule.

For Treasure Valley Hospital Use:

Date Request Received: _____

Date Released: _____ Released By: ☐ E-mail ☐ Fax ☐ Mail ☐ In-Person

Released By: _____Co-Signed By:_____