SMITH COUNTY
MEMORIAL HOSPITAL

Request to Inspect or Copy Health Information

Copy of photo ID required for each request

Please submit this request to Heath Information Management. Personnel from the Health Information Management department at Smith County Memorial Hospital will contact you at the address or phone number below. SCMH may require up to 30 days to release information. After 90 days, if information is not picked up, it will be destroyed.

Patient Health Information Requested

Patient name:_____ Date(s) of Treatment: _____

Address: _____

Telephone: _____ Date of Birth: _____

Email: _____ Fax: _____

Please specify the records you wish to inspect or obtain copies of (please include date(s) of treatment to help us process your request):

Is an electronic copy requested? ☐ Yes ☐ No. If yes, designate format: (e.g., email, flash drive, CD, etc.) for the information requested: _____

Please specify the type of access you are requesting: ☐ inspection ☐ copying.

Please indicate method of delivery if copies are requested:

- ☐ I will pick up the records from the Smith County Memorial Hospital.
- ☐ I authorize the following individual to pick up the records from Smith County Memorial Hospital on my behalf (must sign consent for pick up below):_____
- ☐ Fax
- ☐ Mail (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 (must sign consent to email below)

The purpose of this request is:

- ☐ Change of insurance or physician
- ☐ Referral
- ☐ Other: _____

SMITH COUNTY
MEMORIAL HOSPITAL

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:_____

Consent to Pick Up By Third Party

I authorize Smith County Memorial Hospital (SCMH) to release my records to the individual identified above. I have authorized this individual to pick up a copy of my records from SCMH on my behalf. I understand that these records 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. I further understand that SCMH has no control over the records once they are released to this individual. The records could be lost, stolen or viewed by the individual. I accept these risks and any personal or financial harm which may occur as a result of the individual picking up my records.

_____ _____

Signature of Patient or Patient's Personal Representative Date

Personal Representative's Relationship to Patient:_____

Consent to Email

I request Smith County Memorial Hospital (SCMH) communicate with me or with another individual about me by email at the email address provided on this form. 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:_____