SMITH COUNTY MEMORIAL HOSPITAL
SMITH COUNTY FAMILY PRACTICE

REQUEST TO INSPECT OR COPY HEALTH INFORMATION

Copy of photo ID required for each request

PATIENT HEALTH INFORMATION REQUESTED:

Patient Name: _____

Address: _____

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

DATE(S) OF TREATMENT: _____

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

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

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

- □ Patient Portal.
- □ I will pick up the records from SCMH/SCFP.
- □ I authorize the following individual to pick up the records from the SCMH/SCFP on my behalf:

_____ _____
Name Relationship to patient

I authorize SCMH/SCFP to release my records to the individual identified above. I have authorized this individual to pick up a copy of my records from SCMH/SCFP on my behalf. I understand that these records will contain my protected health information, social information, 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/SCFP 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.

□ Please fax. My fax number is _____.

□ Please mail the records to the following address): _____.

□ Please email to: _____. SCMH/SCFP please transmit via (please check one of the following)
☐ Encrypted or ☐ Unencrypted email.

I understand that I have the right to receive emails from SCMH/SCFP in an unencrypted format. These communications will contain my protected health information, social information, personal identification information (including demographic and financial information), and may include my social security number, date of birth, credit card or banking information. 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 my request for unencrypted 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 SCMH/SCFP harmless from any injury I may incur as a result of email communications.

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:_____

SCMH/SCFP may require up to 30 days to release information. After 90 days, if information has not been picked up, it will be destroyed.

FOR OFFICE USE ONLY

DATE RECEIVED: _____ ACTION TAKEN: _____ YES _____ NO

FORM COMPLETED BY STAFF MEMBER: _____ YES _____NO

Print Name: _____ Signature: _____