



Instructions for completing the Patient Request to Access Protected Health Information (PHI):

1. Complete the first section with your current full name, date of birth, mailing address, e-mail address and phone number. List any names you have previously used (i.e. maiden name) where available, as well.
2. **What records do you want?** Mark the appropriate box(s) for the documents that you are requesting. Please be specific.
3. **From which dates of service do you need records?** Please list specific dates. If you do not remember the specific dates, please indicate at least a time frame such as “last month,” “last six months,” etc.
4. **How would you like to receive your records?** Check the appropriate box. Electronic releases are automatic through the Patient Portal after 07/01/2023. If records are being sent to someone other than the patient, then specify whom the records should be released. CDs or paper records will be mailed to the address provided.
 - a. If records will be picked up by someone other than the patient, the name of the individual picking up the records should be listed. Please complete the name and phone number of the individual who will be picking up your medical records.
5. **Patient/Authorized Representative Signature:** This form should be signed by the patient. If the patient is unable to sign and the request is being made by an authorized personal representative of the patient (parent/guardian of a minor, Power of Attorney, executor of estate, etc.), the Authorized Representative should sign and date the form. Please provide printed name and relationship to the patient. *Supporting legal documentation must accompany this authorization form when signed by an authorized representative.*
6. **A valid driver’s license or photo ID will be required at the time of medical records pick up.**

***Please contact Health Information Management at 785-776-2540 if you have any further questions.*

Manhattan Surgical Hospital – Health Information Management

Attach signed form and email to ROI@manhattansurgical.com or fax to **785-776-5101**

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PATIENT REQUEST TO ACCESS PROTECTED HEALTH INFORMATION (PHI)

Last Name: _____ First Name: _____ Date of Birth: ____/____/____
Address: _____ City: _____ State: ____ Zip Code: _____
E-Mail Address: (Optional) _____ Phone: _____

What records do you want? (Check the appropriate boxes below):

- | | |
|---------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Billing Records | <input type="checkbox"/> Operative Report/Procedure Note |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Nurses' Notes |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> Imaging/Radiology Reports | <input type="checkbox"/> Physician Progress Notes |
| <input type="checkbox"/> Radiology film/tracing/media – provided on CD | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Other (please specify): _____ | |
| <input type="checkbox"/> Complete Medical Record (all notes, results, and discrete data elements) | |

What dates of service do you need records from?

Specific dates(s): _____ to _____ OR | All dates of encounters/visits.

How would you like to get your records? (Check the appropriate boxes below):

Electronic: Patient Portal Secure (Encrypted) E-mail Unsecure (Unencrypted) E-mail Other:

**If you request unencrypted email, your PHI may be at risk of access by unauthorized third parties.*

Paper: Mail In-Person Pickup

**Fees may apply for mailing records on paper or CD.*

I understand that:

I am requesting access to my own protected health information as permitted under HIPAA (45 C.F.R. §164.524). I understand that I may be charged a reasonable, cost-based fee for copies.

Patient/Authorized Representative Signature: _____

Date: _____ Time: _____

Printed Name of Authorized Representative: _____

Relation to Patient: _____

**If signed by a patient-authorized representative, supporting legal documentation must accompany this form.*

HIM/BO Department Use Only:

Identification Verified via _____

DATE STAMP

Medical Record # _____