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_____

Last 4-digits SSN_____Acct#_____MR#_____

2. To what information would you like access?

___ All health information (medical, billing records and other records used to make decisions about me) for all visits **OR** dates otherwise specified for the locations(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

___ Midwest Ear, Nose & Throat-Owensboro

___ Women's Healthcare Partners/Dr. Ottman-Owensboro

___ Fyzical-Owensboro

___ Landmark GastoIntestinal/Dr. Lalama-Owensboro

How would you like to receive the records? Please check one:

___Paper ___CD ___Patient Portal

___Fax-*Please enter fax number:* _____ *enter fax location*: _____

___Encrypted email-*Please enter your email address:*_____

___Unencrypted email-***Please read and initial that you acknowledge and accept the risk that this is an unsecure method of delivery and that the records may be intercepted while being sent-_____****please enter your email address:*_____

If you selected receipt of paper or a CD, records will be:

___ Reviewed and/or picked up by you in person

___ Picked up by someone you choose. That person is 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 (address same as on page 1)

___ Sent to provider. Please fill in the name and address of provider:_____

_____

___ Mailed to you at another location? Please fill in the address: _____

_____

___ Mailed/emailed to someone else at another location? Please fill in the name and address:_____

_____

4. **Please read and initial that you understand the important information below_____**
   a. 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_____

Relationship, if not patient_____Witness_____

Office use only

Identity verified by: _____Photo ID _____Other Specify

Records mailed/faxed/e-mailed/picked-up (circle) by: _____Date:_____