REQUEST TO ACCESS PROTECTED HEALTH INFORMATION (PHI)

NOTE: Please complete all fields to prevent delays in our response

Patient Name: ____ Birth Date: _____________
Printed (First) (MI) (Last Name)

Address: ____ Telephone #: ____________
Street Address City State Zip Code

I request that: Renown Health ***(circle one)*** **SEND TO** ***-or-*** **RECEIVE FROM the below entity:**

____ Telephone #: ___________ Fax: ___________
Full Name/Entity

Address: ____
Street Address City State Zip Code

For Date(s) of Service from: ____________________ **to** ____________________ [**Dates MUST be specified**]

Information To Be Disclosed: **Unless item is marked below it will not be disclosed**

□ Entire Medical Record (All records in the Designated Record Set; includes billing and radiology films/CDs)
□ Other (please specify): ____

Format Records Are To Be Disclosed:
□ Paper copy
□ CD with password encryption
□ PDF (Upload to Renown Epic MyChart Account)
□ Other (please specify): ________________

Record Delivery
□ Mail to the address listed above
□ Fax to the address above
□ MyChart (PDF upload only)
□ Call at number above for pick-up

I UNDERSTAND THAT:
- This Request is effective immediately.

Signature of PATIENT ONLY:________________________ Print Name:________________ Date:__________

Signature of Person Who Is NOT the Patient:____________________________________ Date:__________
Print Name: ____________________________ **Authority to Sign**: ______________________________
Proof of Authority MUST be attached (except for parents)
Address: ____ Tel No: ____________

*****Completed by Staff Member Fulfilling & Verifying Request & Completeness *****

Date: ___________ Time: ________ Verified By: ______________________________________

MR #: _________________________ Account #: ___________________________________
List Document Used to Verify (attach a copy): ____
Provider Signature for Release of Psychiatric/Mental Health Records: ______________________________
Printed Provider Name: ____ Date: ____________________