SEARHC
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

HEALTH INFORMATION MANAGEMENT
REQUEST FOR PERSONAL HEALTH INFORMATION (PHI)

This form is for requests to view, receive, or send copies (to self or another party) of their own medical information. Please allow up to 30 days for SEARHC to process your request. Incomplete forms will be returned.

Printed Name of Patient:		Date of Birth (MM/DD/YYYY):	
Daytime Telephone Number:	Printed name of personal representative and relationship to patient (if applicable)* ____ *legal documentation may be required to confirm the authority of the personal representative		
Information to be released from:		Information to be released to:	
Street Address:		Street Address:	
City:		City:	
State:	Zip Code:	State:	Zip Code:
Phone Number:		Phone Number:	
Fax Number:		Fax Number:	

Information Requested:
____ Medical Records from the last two years ____ Complete Designated Record Set
Date(s) of service: _____/_____/_________ through _____/_____/_________
_____ Emergency Room Records _____ Discharge Summary _____Health Summary _____ Accounting of disclosures
_____ Physician Progress Notes _____ Nursing Notes _____ Billing records _____ Registration Records
_____ Test Results (Lab, Radiology Report, Pathology) *Please Specify*: ______________________________
_____ Other (Immunization Record, Medication Lists) *Please Specify*: ______________________________
_____ Other: ______________________________

Please check all that apply to your request:

____ I am requesting access to review my medical information from SEARHC in person. An appointment will be made for you to review your records with the HIM manager. Your appointment is _______________ at ____________
Location: ______________________________

I am requesting paper copies of my SEARHC medical information to be (check one):
____ picked up by me ____ mailed to me (at address above) ____ faxed to me (at number above)
____ I am requesting paper copies of my SEARHC medical information to be picked up by ______________________
____ I am requesting paper copies of my SEARHC medical information to be mailed to the person listed above
____ I am requesting electronic copies of my SEARHC medical information be sent via encrypted email
____ I am requesting electronic copies of my SEARHC medical information be sent via unencrypted email*
Email address: ______________________________

*Please note: any medical information sent via unencrypted email is inherently not secure and could result in the information being read or otherwise accessed/tampered with while in transit.

Your records may contain sensitive information such as STD, mental health, or substance abuse information. This information will be released if it is part of the information being requested to disclose.

Signature: ______________________________ Date: ____________________
ID # ______________________________

There may be a fee associated with processing the request. Staff will inform you if the fee applies.

For Facility Use:

Date Received:	Date Released:	MRN#	Acct #.	ROI #:	Released by:

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