BLUE RIVER
Family Medicine

REQUEST TO ACCESS AND COPY PROTECTED HEALTH INFORMATION

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____ Phone: _____

Address: _____City:_____State:_____ Zip Code:_____

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

☐ Complete Medical Record (all notes, results, and discrete data elements)

☐ Billing Records
☐ Encounter Summaries
☐ Imaging/Radiology Reports
☐ Radiology film/tracing/media (provided on CD)
☐ Vaccination Records
☐ Operative/Procedure Reports
☐ Physician Orders
☐ Physician Progress Notes
☐ Lab Reports
☐ Prescription Medication List

☐ Other/Outside records (please specify): _____

Covering the period of heath care from:

☐ Specific Date(s): _____to _____ OR ☐ All dates of encounters/visits.

How would you like your records delivered? (Choose preferred option(s) below)

Option #1: **Electronic**: ☐ Patient Portal ☐ Secure (Encrypted E-mail) ☐ Unsecure (Unencrypted E-mail) ☐ Fax

Option #2 **Paper**: ☐ Mail ☐ *In-Person pick-up

***For In-Person pick-up ONLY:**

If records are going to be picked up by someone other than the patient, the name of the individual picking up the records should be listed here:

I request my medical information to be released to:

Name:_____ Phone:_____

Address:_____

I request my records to be sent to:

☐ Self/Family ☐ Health Care Provider ☐ Insurance ☐ School ☐ Employer ☐ Other:_____

Name:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Fax Number: _____

E-mail Address (if applicable): _____

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I understand that:

- Requests for copies of medical records and/or non-document material may be subject to copying fees.
- Medical record information may include records related to mental health care, communicable diseases, HIV/AIDS, genetic testing, and/or alcohol drug/abuse. I authorize the release of these records.
- Information delivered through email is inherently unsecure unless it is fully encrypted. Requesting that my records are sent to an unsecured email address is not a secure delivery method and there is risk that my health information may be intercepted and/or viewed by unauthorized persons. Manhattan Surgical Hospital is not responsible for a third party's unauthorized access to my personal health information delivered in this format or any risks (e.g., virus) potentially introduced to my computer/device when receiving personal health information through unsecure email.
- Protected health information provided on portable electronic media may not be encrypted and may be at risk for inadvertent disclosure if you lose the media or it is stolen. By requesting the use of portable electronic media, you accept this risk.

If you just wish to review your information and do not want information copied or reproduced, initial here _____.

Patient/Authorized Representative Signature*_____ Date: _____ Time: _____

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

Printed Name of Authorized Representative: _____

Relationship to Patient: _____

Send completed form to: Blue River Family Medicine
8301 Positano Drive
Manhattan, Kansas 66502
FAX: 785-587-0558