1110926

HILLCREST HEALTHCARE SYSTEM
TULSA, OKLAHOMA 74104

REQUEST FOR ACCESS TO PATIENT'S HEALTH INFORMATION
HMC926 (03/12)

Form No. HIPAA-F20

As a patient of HILLCREST MEDICAL CENTER, you are entitled under federal law to access your personal protected health information maintained in a "designated record set." In order to process your request for access to this information, please complete this form and submit it to the Medical Records Department. When received by the Medical Records Department, he or she will use the information to verify your identity and process your request. If you have any questions or concerns, please contact Medical Records Department at 918-579-2000.

Patient Information: Patient Name_____ Phone Number_____

Birth Date_____ Social Security Number_____ Date of access request_____

Patient Address_____

Information Requested: Account #_____ MRN_____

Please indicate specifically the information to which you are requesting access Date of Service_____

_____

Access Method: *You have the right to view your protected health information, obtain a copy of the information, or both. Please indicate below whether you wish to view the information only, obtain a copy or both. If you select "copy", please indicate your method of delivery.*

☐ I would like to request an electronic copy of my discharge instructions.

☐ I would like to view my protected health information. I have/will schedule(d) an appointment with HILLCREST MEDICAL CENTER to view my health information on _____. I understand HILLCREST MEDICAL CENTER may have a staff member sit down with me as I review my health information.

☐ I would like a paper copy of my protected health information. I understand HILLCREST MEDICAL CENTER may charge me a fee for the copies (including faxed copies) according to relevant state law. I also understand that I may be required to pay the fee in full before I can obtain the copy. I have selected my delivery method below (if none is selected, I will pick up the copy at the facility.)

- ☐ I will return to HILLCREST MEDICAL CENTER and pick up the copy when its ready.
- ☐ I would like HILLCREST MEDICAL CENTER to send the copy via U.S. mail to the following address: I understand HILLCREST MEDICAL CENTER may charge me all applicable postage fees.

  _____
- ☐ I would like HILLCREST MEDICAL CENTER to send the copy via facsimile to the following number

  _____.
- ☐ I would like an electronic copy of my patient health information as defined here (including diagnostic test results, problems, medications, allergies, discharge summary, and procedures). *I understand that HILLCREST MEDICAL CENTER has three business days to provide this copy.* I would like my copy sent to me electronically using the following format

  _____

  If HILLCREST MEDICAL CENTER cannot readily produce the information in the form or format you have requested, such Information will be made available to you in a readable hard copy form or format agreed to. ***We are unable to provide an electronic copy of your legal record at this time.***

☐ I would like HILLCREST MEDICAL CENTER to provide to me a explanation or summary of the information provided. I understand that HILLCREST MEDICAL CENTER may charge a fee of $_____ for the explanation or summary, and I may be required to pay the fee in full before I can obtain the explanation or summary.

I understand that HILLCREST MEDICAL CENTER is given thirty days to process my request for access if my information is maintained on-site, sixty days if the information is maintained off-site, and that HILLCREST MEDICAL CENTER may extend the deadline by an additional thirty days if I am notified in writing of the extension. I further understand that my rights are limited to any information in my medical record as compiled by HILLCREST MEDICAL CENTER.

By signing below, I acknowledge and agree to the above conditions.

Date	Patient Signature	Parent/Guardian Signature	Relationship to Patient

1113504

Hillcrest Medical Center Childrens Medical Center
Kaiser Medical Center
TULSA, OK 74104

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
HMC 3504 (REV. 08/08)

PATIENT NAME: _____ Social Security # _____

DATE OF BIRTH: _____ Medical record # _____

I hereby authorize _____ and its duty authorized agents and employees to

___ use of or disclose to OR ___ obtain the Protected Health Information described below: (check appropriate box)

NAME OF INDIVIDUAL OR INSTITUTION: _____

ADDRESS: _____

Information authorized for use or disclosure, or to be obtained:

___ History & Physical ___ Discharge Summary ___ Operative Report ___ ER Record ___ Consultation ___ Lab reports

___ Progress Notes ___ X-ray reports ___ Other _____

___ Medical Information between _____ to _____

The information will be obtained, used, or disclosed for the **following purpose** only:

___ Insurance ___ Continued treatment ___ Legal ___ At the request of the patient or patient's representative

___ Other (specify) _____

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already retained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights. Unless revoked, the automatic expiration date will be six (6) months from date of signature or upon occurrence of the following event: _____
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information. The entity authorized to disclose the information will not be compensated by the recipient for such disclosure. Normal applicable fees, such as copy fees, may apply.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released, unless prohibited by law and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on obtaining this authorization.

I understand that my medical information may indicate that I have a communicable or noncommunicable disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses also knows as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____
SIGNATURE OF PATIENT DATE

_____ _____
SIGNATURE OF PERSONAL REPRESENTATIVE DATE

_____
DESCRIPTION OF REPRESENTATIVES AUTHORITY TO ACT FOR THE PATIENT

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or veneral disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

Original: Releasing entity Copy: Originator