



*One Team United in Caring*

## PATIENT REQUEST FOR MEDICAL RECORDS

The Federal HIPAA regulations on patient privacy and confidentiality allow patients the right to access certain information and records contained in their designated record set. You have the right of access to copy or inspect certain parts of your medical information held by Knox Community Hospital. We are not always required to grant such access but each request will be carefully reviewed and approved if warranted. You will be notified within 30 days if your request has been approved or denied and the reasons for any denial.

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Home telephone number \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please provide as much detail as possible regarding the medical information you wish to review below:

I wish to: (Check one)

Personally pick up copies of my medical records to take to my physician for continued medical care.

Receive a copy by mail of the information listed above.

**NOTE:** If you request copies of the information, we will charge you \$2.50 per page, for the first ten (10) pages. Fifty-one cents (\$.51) per page for pages eleven (11) through fifty (50). Twenty-five cents (\$.20) for pages fifty-one (51) and higher per page and postage which is payable to Knox Community Hospital.

Come in and inspect the information listed above.

Come in and inspect the information listed above and pick up a copy at the same time.

**NOTE:** If you request copies of the information, we will charge you \$2.50 per page, for the first ten (10) pages. Fifty-one cents (\$.51) per page for pages eleven (11) through fifty (50). Twenty-five cents (\$.25) for pages fifty-one (51) and higher per page and postage which is payable to Knox Community Hospital.

Other \_\_\_\_\_

PLEASE READ AND COMPLETE BACK SIDE

PLEASE READ:

We are permitted by law to deny part or all of your request for access for one or more of the following reasons:

- Your access request form is not signed by you or your representative;
- Your access request form is signed by your representative and the representative has not provided information on the source of his/her authority to act for you;
- We do not maintain the information you have requested to copy or inspect;
- The information you have requested is not part of your records.
- Your request is for psychotherapy notes;
- Your request includes information compiled for litigation;
- Your request includes information held by our laboratory that is not accessible by law;
- Your request includes information created or obtained in the course of research still in progress that includes your treatment and you agreed to this denial of access when consenting to participate in the research;
- A licensed health professional has determined that the requested access is likely to either endanger your or another person's life or safety or cause substantial harm to you or another person;
- Your request is to copy information and you are an inmate in a correctional facility (you retain the right to inspect the information);
- Your request relates to certain information that was obtained from a confidential source and we are not required to provide access to it by law.

Print Name \_\_\_\_\_

Signature/Date \_\_\_\_\_  
(Patient or Patient's Legal Representative)

**NOTE** that no access request will be processed unless you or your representative has signed this form.

If you are a patient representative, provide documentation or explanation of your authority to act for the patient.

\_\_\_\_\_  
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