310 E. Third St.
Scott City, Kansas 67871
620-872-5811 (Fax) 872-7193

REQUEST TO INSPECT OR COPY HEALTH INFORMATION

Please submit this request to our Privacy Officer/Contact Person. If you have any questions, comments or complaints, or would like to review or obtain a copy of our Notice of Privacy Practices, please contact:

Joe Meyer or Dorsi Cupp

Scott County Hospital

310 E. Third St., Scott City, KS 67871

Telephone: 620-872-5811___

PATIENT HEALTH INFORMATION REQUESTED:

Patient Name:____ Date(s) of Treatment:_____________________________

Address:____

Telephone:______-_______-_______ Date of Birth:_____/_____/_____ Social Security Number:______-_____-___

RECORDS REQUESTED:

Please specify the records you wish to inspect or obtain copies of (please include date(s) of treatment to help us process your request):

□ UB-92 (837-I)_____________________________________
□ HCFA 1500 (837-P) or (837-D)_______________________
□ Detail bill____
□ Advance Directive___________________________________
□ Amendments____
□ Anesthesia Records__________________________________
□ Assessments (i.e., nursing, MDS, OASIS, etc.)___________
□ Care Plan____
□ Consent for treatment forms__________________________
□ Consultation reports__________________________________
□ Diagnostic study results (e.g., laboratory, radiology, pathology, etc.)_________________________________
□ Discharge instructions________________________________
□ Discharge/narrative summary___________________________
□ E-mail containing patient-provider or provider-provider communication_____________________________________
□ Emergency department record__________________________
□ Graphic records_____________________________________
□ Immunization record__________________________________
□ Medication records___________________________________
□ Multidisciplinary progress notes/documentation__________
□ Notes____
□ Operative and procedure reports_______________________
□ Orders____
□ Patient-submitted correspondence, documentation________
□ Practice guidelines or protocols/clinical pathways that embed patient data__________________________________
□ Problem list____
□ Procedure reports____________________________________
□ Records of history and physical examination____________
□ Source data:____
 (a) analog and digital patient photographs for identification purposes only
 (b) diagnostic films and other diagnostic images
 (c) electrocardiogram tracings
 (d) fetal monitoring strips
□ Therapy/rehabilitation records (i.e., occupational, physical, respiratory, speech)_________________________________
□ Treatment related correspondence______________________
□ Video/photographs___________________________________

Please specify the type of access you request (e.g., inspection, or copying):____

Where may we contact you with questions about this request or to set up a time to inspect the records if requested (include address, phone number, and the best time to call): ____
____
____

Please indicate method of delivery if copies are requested:

- □ I will pick up the records from Hospital or Clinic
- □ Please fax. My fax number is______________________________.
- □ Please mail the records to the following address (Please note we can only send records to the patient whose medical information is being requested. All other requests must be made through an Authorization):

  ____

I request access to the health information and records indicated on this form as set forth above. I certify that the records sought are my own or that I am the personal representative of the patient whose records are sought and am authorized to make this request.

____ _____________________________________

Signature of Patient or Personal Representative **Date**

Personal Representative's Relationship to Patient:____

(PROVIDE THE PATIENT A COPY OF THIS FORM UPON COMPLETION)