CARDINAL HILL® REHABILITATION HOSPITAL

USE THIS FORM IF PATIENT OR PATIENT'S REPRESENTATIVE PERSONALLY REQUESTS PHI
(including but not limited to via phone, fax, email, etc.)

PATIENT REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

SECTION 1: PERSONAL INFORMATION

Name: ____ Date of Birth: _______/ _______/ _______

Address: ____ Phone: ( ) ______________________

SECTION 2: HEALTH INFORMATION REQUESTED

____ Entire Medical Record	____ History and Physical	____ Laboratory Reports
____ Entire Billing Record	____ Discharge Summary	____ Radiology Reports
____ Physician Orders	____ EKG, EEG, EMG Reports	____ Consultation Reports
____ Progress Notes	____ Abstract	____ Other, Specify:

Dates of Service Requested (if needed): ____

Requested Delivery Method (e.g. Mail, Email, CD, etc.) ___________________________________

SECTION 3: TO BE COMPLETED IF PATIENT/PATIENT REPRESENTATIVE IS DIRECTING ANOTHER INDIVIDUAL TO ACCESS PHI.

Name: ____

Address: ____

Phone Number: ____

Relationship: ______________________________ (e.g., spouse, mother, father, daughter, son, attorney, etc.)

Encompass Health MAY IMPOSE A FEE TO COVER THE COST OF LABOR, COPYING, AND POSTAGE

____ _________________________

Signature of patient or patient's representative **Date**
(form MUST be completed before signing)

©2018 Encompass Health Corporation
Revised 9/30/16

REORDER # EH-FM-1255738