If requesting your protected health information for release to yourself, complete the next page and mail to:

Health Information Department
Saint Francis Medical Center
2620 West Faidley Ave., P.O. Box 9804
Grand Island, NE 68802-9804

If you have questions please call the Health Information Department at 308-398-5658.

SAINT FRANCIS MEDICAL CENTER
2620 West Faidley Ave, PO Box 9804
Grand Island, NE 68802-9804, 308/398-5658

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Name: _____ DOB: _____
Medical Record#:_____

Address: _____ Phone: _____
(Including street, city, zip)

Health record or contents requested:

__Face Sheet	__Diagnostic Reports	__Emergency Room Report
__Discharge Summary	__Diagnostic Films	__Immunization Record
__Physician Orders/Progress Notes	__Operative Report	__Psychological/CD Eval
	__Pathology Report	__OP Clinic Notes
__History and Physical	__Electronic medium	__Treatment/Aftercare
__Consultation Reports	__Verbal Release	__ Photograph (not for media)
__Physical Therapy Notes	__Residential Summary of Care	

__Other (please specify) _____

Please explain why you are requesting access to the above mentioned health record:

_____

_____

Dates of treatment to be accessed:

_____

Should your request for access be accepted, you will receive a summary of this information. If you would like to receive your information in a different format (i.e. copy of entire health record, onsite review, etc.), please indicate:

_____

_____

Do you agree to receive a summary of the requested information in lieu of access to the entire record?

_____Yes _____No

Saint Francis Medical Center may impose a fee to cover the cost of labor, copying, postage, and preparing a summary of the requested information. The fee will be assessed according to Saint Francis Medical Centers Fee Schedule for Cost of Copies. Do you agree to such fees imposed by Saint Francis Medical Center for providing a copy or summary of the requested information?

_____Yes_____No

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I understand that the provider may or may not grant access to my health record. In any event, this request for access will be made a part of my permanent health record.

_____ _____
Signature of Individual or Personal Representative Date

_____ _____
Relationship to Individual Witness