PeaceHealth

Request for Copy of Protected Health Information

You have a right under federal law to request a copy of your health information.

How to request a copy of your health information:

1. Complete the *Request for Copy of Protected Health Information* form.
   To prevent possible delays in processing your request, please carefully complete the form including:
   - Your complete address and phone number in case we need to contact you about your request.
   - The date by which you need the records in the section "Date records needed". For urgent requests, please call 1-844-962-2090 or 360-729-1300.
   - If you are a parent, guardian or personal representative, please include your relationship to the patient in the section "Relationship to Patient" and provide the required documentation.
   - Please clearly state where and how you want the records to be delivered.
2. Return the request form using one of these methods:
   - **Email:** ReleaseofInfo@peacehealth.org
   - **Fax:** 360-527-9383 *(If you are completing this request at a PeaceHealth facility, you may ask a caregiver to fax the form on your behalf.)*
   - **Mail:** PeaceHealth Health Information Management (HIM) Department, ROI Services
     1115 SE 164th Avenue, Dept.336
     Vancouver, WA 98683

What to expect after you have submitted a request form:

- Your request will be processed within 15 business days for Washington State and 30 days for Oregon and Alaska.
- An invoice then will be mailed to you (if there are charges).
- After payment has been received, the records will be delivered in 5-7 business days, depending on the type of records and the dates of service requested.
- If we are unable to process your request within 15 business days for Washington and 30 days for Oregon and Alaska, we will contact you to let you know the reason for the delay and the anticipated processing date.

Receiving your records:

- You may choose to receive your health information by paper, electronically on a CD or via encrypted e-mail.
- PeaceHealth uses an e-mail encryption system to protect confidential e-mail messages. If you choose to receive your health information via encrypted e-mail, you will receive a notification e-mail containing a link to access the full message on our Secure E-mail Server. Directions will be provided in the email for you to create a user account to receive your information.
- Please note, unencrypted e-mail transmitted via the internet has a risk of being intercepted by unauthorized individuals.
- After 15 business days for Washington State and 30 days for Oregon and Alaska, if you have not received your records or been contacted, please check your email spam/junk folder, prior to contacting HIM

(This page goes to patient-Do not scan into record)

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Request for Copy of Protected Health Information

Note: To avoid delays, please print clearly and sign. (* = **REQUIRED FIELDS**)

***INFORMATION ABOUT THE PATIENT WHOSE RECORDS ARE BEING REQUESTED:**

*Patient Name: Last _____ *First _____MI _____
*Street Address _____ Daytime Phone _____
*City, State, Zip _____ Evening Phone _____
*Date of Birth _____ ***Date Records Needed**: _____

***WHAT FACILITY'S RECORDS ARE NEEDED?** (check all that apply)

Location	Hospital	PHMG
Springfield	❑ Riverbend Hospital	❑ Clinic
Eugene	❑ University District	❑ Clinic
Cottage Grove	❑ Cottage Grove Hosp	❑ Clinic
Florence	❑ Peace Harbor Hosp	❑ Clinic
Vancouver	❑ Southwest Hospital	❑ Clinic

Location	Hospital	PHMG
Longview	❑ St John Hospital	❑ Clinic
Bellingham	❑ St Joseph	❑ Clinic
Friday Harbor	❑ Peace Island Hosp	❑ Clinic
Sedro-Woolley	❑ United General	❑ Clinic
Ketchikan	❑ Ketchikan Hosp	❑ Clinic

Other Location: _____

***SEND RECORDS TO (RECIPIENT):**

❑ Send to patient address above **OR**

❑ Facility Name_____

Street Address: _____

_____

City/State/Zip: _____

***HOW TO SEND RECORDS:**

❑ Mail to Recipient Address
❑ Fax to number: _____
❑ Email to: _____
❑ Other delivery method (describe): _____

_____

***VISIT DATE RANGE NEEDED (SELECT ONE):**

❑ Specific: (from) _____ (to) _____
❑ One-year history _____ ❑ Other: _____

***INFORMATION NEEDED:**

❑ Provider documentation, medication list and diagnostic information: Lab, X-ray, EKG (these are the most commonly requested items)
❑ Imaging Films ❑ Billing Records ❑ Other (specify): _____
❑ Complete medical records, this would include all records including billing records for dates identified above.

Acknowledgements:

1. I understand that I may be charged a reasonable, cost-based fee that covers the cost of copying, including supplies, labor, and postage.
2. I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, genetic information, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).
3. I understand I must provide legal documentation if I am the guardian or Medical Power of Attorney.

***Requester:** (print your name here) ***Signature:** _____ ***Date:** _____

Relationship to Patient: ❑ Patient (self) ❑ Parent/*legal guardian ❑ *DPOA ❑ Other: _____

* Please attach proof of guardianship/DPOA (medical power of attorney) with this request.

OPTIONS FOR RETURNING THIS COMPLETED FORM: Fax: 360-527-9383 Email: releaseofinfo@peacehealth.org

Mail to: PeaceHealth, ATTN: HIM ROI; 1115 164th Ave, Dept 336, Vancouver, WA 98683

Questions? Call 1-844-962-2090

DocType Description – ROI (Release of Information Authorization)