RUSSELL REGIONAL HOSPITAL
200 South Main St. • Russell, KS 67665-2997 • (785) 483-3131
West Central Kansas Association, Inc. d/b/a

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:

HOSPITAL

Privacy Officer
200 S. Main St.
Russell, KS 67665
Telephone: 785-483-3131

CLINIC

PATIENT HEALTH INFORMATION REQUESTED:

Patient name:_____ Date(s) of Treatment: _____

Address: _____

Telephone: _____-_____-_____ Date of Birth: _____/_____/_____

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):

☐Billing Records _____
☐Anesthesia records _____
☐Consultation reports _____
☐Diagnostic study results (e.g., laboratory, radiology, pathology, etc.) _____
☐Medication records _____
☐Physician Orders _____
☐Respiratory Therapy Records _____
☐Advance directives _____
☐Emergency department record _____
☐Immunization record _____
☐Discharge/narrative summary _____
☐Operative and procedure reports _____
☐Physician Notes _____
☐History/Physical Records _____
☐Social Work Reports _____
☐Therapy/rehabilitation records (i.e., occupational, physical, respiratory, speech) _____
☐Other _____

Is an electronic copy requested? ___ Yes ___ No. If yes, designate format:(e.g., PDF, CCDA, image, picture, etc. for the information requested): _____

Type of access you are requesting (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 best time to call): _____

_____

Please indicate method of delivery if copies are requested:

- ☐ I will pick up the records from the Hospital/Clinic.
- ☐ I authorize the following individual to pick up the records from the Hospital/Clinic on my behalf (must sign consent for pick up below) _____.
- ☐ Please fax. My fax number is _____.
- ☐ Please mail the records to the following address (Please note that we can only send records to the patient whose medical Information is being requested. All other requests must be made through an Authorization): _____

_____

_____

- ☐ Email to: (must sign consent to email (below): _____

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 Patient's Personal Representative Date

Personal Representative's Relationship to Patient: _____

CONSENT TO PICK UP BY THIRD PARTY

I authorize Russell Regional Hospital/Clinic to release my records to the individual identified above. I have authorized this individual to pick up a copy of my records from the Russell Regional Hospital/Clinic on my behalf. I understand that these records will contain my protected health information, social information, my personal identification information (including demographic and financial information), and may include my social security number, date of birth, credit card or banking information. I further understand that Russell Regional Hospital/Clinic has no control over the records once they are released to this individual. The records could be lost, stolen, or viewed by the individual. I accept these risks and any personal or financial harm which may occur as a result of the individual picking up my records.

_____ _____
Signature of Patient or Patient's Personal Representative Date

Personal Representative's Relationship to Patient: _____

CONSENT TO EMAIL

I request Russell Regional Hospital/Clinic communicate with me or with another individual about me by email at _____. I understand that these communications will contain my protected health information, social information, my personal identification information (including demographic and financial information), and may include my social security number, date of birth, credit card or banking information. This information may not be encrypted when sent and may not be completely secured. I understand that the confidentiality of my information may not be completely secured. I understand that electronic communications may be intercepted during transmission, may be misdirected or may be otherwise obtained by third parties. I accept these risks and any possible personal or financial harm which may occur as a result of electronic communications.

I also realize that my email may not actually be received, opened, read or responded to in a timely manner. If I rely upon email, I realize my condition could worsen before I get a response and that I could be harmed as a result of waiting for an email response. I knowingly accept this risk. I realize and hold hospital/clinic harmless from any injury I may incur as a result of email communications.

_____ _____
Signature of Patient or Patient's Personal Representative Date

Personal Representative's Relationship to Patient: _____

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

ROI CHARGES: Paper $0.015 x _____ pgs. = _____ Discs $.30 each x _____ = _____

Labor $4.00 / 15min. x _____ = _____ Envelopes $.05 each x _____ = _____

10 x 13 manila $.19 each x _____ = _____ 7.5 x 10.5 manila $.18 each x _____ = _____

Postage = _____

TOTAL CHARGES = $_____

___Patient Received Copies