PATIENT RIGHT OF ACCESS FORM

*******Please Note: Reasonable charges MAY apply*******

Patient Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Date of Birth: ______________________________

Patient Phone Number: ______________________________

Medical Record #: (if known) ______________________________

I am requesting a copy of my Protected Health Information (PHI) in the Geisinger* Designated Record Set pursuant to the HIPAA Right of Access regulations. I am requesting records from the following entities:
☐ All Sites ☐ Specific Clinic(s) or Hospital(s) ______________________________ .

Please produce records form the following dates: ____/____/____ to ____/____/____ ("present" equals date of signature).

SPECIFIC PHI TO RELEASE - (Check box of items to be released)

☐ Clinic Notes
☐ Colonoscopy
☐ Consultation Report(s)
☐ Disability/FMLA Form
☐ Discharge Summary
☐ EEG, EKG, Stress Test
☐ Emergency Department Notes
☐ Endoscopy

☐ History and Physical
☐ Immunizations
☐ Itemized Bills
☐ Laboratory Reports
☐ Medications
☐ Operative Reports
☐ Pathology Reports
☐ X-Ray Films

☐ X-Ray Reports
☐ HIV/AIDS
☐ Alcohol/Substance Use Disorder
☐ Mental Health/Rehabilitation
☐ Other
____
____
____
☐ Any and all

I am requesting that this PHI be sent in the selected form or format:

Recipient Address: ☐ Myself
☐ Legal Representative
Name: ______________________________
Address: ______________________________
____
Phone: ______________________________
Fax: ______________________________
Email: ______________________________

Format: ☐ MyGeisinger (pdf format)
☐ US Mail (paper format)
☐ CD (secure pdf format)
☐ Fax
☐ Email (you will receive a link or instructions to download)
☐ Other (Please specify)
____

IMPORTANT INFORMATION: I understand that if I ask Geisinger to disclose PHI to another individual or entity, that information may no longer be protected by Pennsylvania and Federal privacy laws, including HIPAA. I understand that Geisinger will make reasonable attempts to produce the documents in the format requested; however, if the records are not readily reproducible in that format, I understand Geisinger will call to discuss alternative delivery options. In certain limited circumstances, Geisinger may deny a request. If a request is denied, I understand I will be given a written explanation, and a description of steps I may take in response to the denial.

SIGNATURES

NOTE: IF PATIENT IS UNDER 14 YEARS OF AGE AND IS NOT EMANCIPATED MINOR THE PARENT OR GUARDIAN MUST SIGN. IF BETWEEN THE AGES OF 14-18 YEARS OF AGE, BOTH PATIENT AND PARENT/ GUARDIAN MUST SIGN.

Date/Time: ______________ **Patient Signature**: ______________________________

If patient is unable to sign authorization form because of physical condition or age, complete the following:
Patient is a minor or patient is unable to sign authorization because: ______________________________

Date/Time: ______________ **Signature**: ______________________________

Description of personal representative's authority to act for the patient: ______________________________

(Parent/legal or personal representative with authority under State law to make health care decisions for the patient)

*Throughout this document, the term "Geisinger" shall refer to those corporate affiliates within the health care system which are involved in the provisions of health care services and related support services. Geisinger is comprised of Geisinger Health ("GH") as parent and all subsidiary corporate entities.