YORK GENERAL

PDAPHI

Patient Directed Request for Health Information (Medical record release)

Complete this form if you want York General to give a copy of your Protected Health Information (or PHI) to yourself or another person, such as your spouse or employer. PHI may include, but is not limited to: Medical records, billing statements, laboratory or pathology, radiology/ultrasound records and other medical information. (We do not release sensitive lab results and psychotherapy notes) HIM is still two different systems. Please mark which records below.

☐ **York General Hospital** ☐ **Family Medicine (YMC)** ☐ **Urgent Care (Quick Clinic)**

Patient Name:_____ Date of Birth: _____/_____/_____

Address:_____City:_____ State:_____ Zip:_____

Phone:_____

I request my PHI to be disclosed:

To myself and/or the following:

Purpose: ☐ Litigation ☐ Disability ☐ Insurance ☐ Work Comp ☐ Self/Personal Copy ☐ Specialist ☐ Transfer of Care ☐ Other _____

Recipient Name	Relationship to you	Address	Telephone

How should they be delivered?

_____ Mailed

_____ Picked Up

_____Faxed to number:_____

_____ Emailed. The patient agrees this carries added privacy and security risks but still wants records emailed to _____ (address)

Hospital records: Date Range_____to_____

☐ ALL of the below. Or select those items you only want released

- ☐ Inpatient
- ☐ Outpatient
- ☐ Specialty Clinic
- ☐ Lab/Path Reports
- ☐ Operative/Procedures
- ☐ Radiology/XRay/MRI
- ☐ Emergency Department
- ☐ Therapies

Clinic records: Date Range_____to_____

- ☐ Physician Office Notes
- ☐ Cardiology/EKG Reports
- ☐ Immunizations
- ☐ Lab/Path Reports
- ☐ Operative/Procedure Reports
- ☐ Radiology/XRay/MRI Reports
- ☐ Other _____

Authorization automatically expires 12 months after original date of request):

I understand once my PHI has been released, it is no longer protected by the federal privacy regulations. I may **revoke or change** this request at any time by submitting a request in writing to the Privacy Officer at York General Hospital.

_____ _____

Signature of Patient or Authorized Representative Date

(Must provide copies of Legal paper work for legal representative)

_____ _____

Print Name Relationship to Patient (if applicable)