

## Patient Directed Request for Health Information (ROI)

Complete this form if you want YGH 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.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

I request my PHI (excluding sensitive lab results ☐; psychotherapy notes ☐; reproductive health notes) ☐

**from York General to be disclosed:** to Self and/or the following:

Authorization applies to ALL PHI, unless specified here:

Recipient Name	Relationship to you	Address	Telephone

How should they be delivered?

\_\_\_\_\_ Mailed

\_\_\_\_\_ Emailed. The patient agrees this carries

\_\_\_\_\_ Picked Up

added privacy and security risks but still wants records

\_\_\_\_\_ Faxed to number: \_\_\_\_\_

emailed to \_\_\_\_\_

(email address)

**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)

**\*For Staff Use Only\***

**(When releasing records, have the patient fill out this form or if there is already a continuous authorization on file, print it from their chart, fill out the chart below and route the completed form to HIM for record keeping.)**

Date Released	Released By:	Released to:	Encounter Number: