OSF HEALTHCARE

REQUEST for ACCESS to PROTECTED HEALTH INFORMATION (PHI)
By Patient or Patient Representative

To our Patients and Patient Representatives: Please use this form to request access to your Protected Health Information (PHI) in your designated record set that we maintain. You generally have the right to inspect and/or obtain a copy of your PHI in your designated record set from OSF HealthCare. We are allowed 30 days to respond to your request, and may be granted one 30-day extension.

PATIENT INFORMATION	Patient Name: _____ Address:_____ City, State, Zip Code:_____ Email: _____ Phone Number: _(_____)_____ Date of Birth: _____ Social Security Number(Last 4 digits):XXX-XX- __ __ __ __
PROVIDER/ORGANIZATION: (Who you authorize to release your information)	**I hereby authorize:** ***OSF Healthcare*** Dixon - Saint Katharine Medical Center - 403 E. First Street, Dixon, Illinois 61021
PERSON OR ENTITY TO RELEASE INFORMATION TO:	Name or Entity: _____ Address:_____ City, State, Zip Code:_____ Email: _____ Phone Number: _(_____)_____
INFORMATION TO BE DISCLOSED:	☐ Abstract ☐ Entire Medical Record ☐Lab Results ☐ Radiology Results☐Imaging Films ☐Medical Bills ☐Other(please be specific):_____ Date(s) of Visit: _____
DELIVERY:	☐ OSF MyChart- same day to 3 days from receipt of request *to sign up, visit* www.osfmychart.org ☐ Encrypted Email – 3 to 5 business days ☐ USPS Mail - 3 to 10 business days from receipt of request If sending by USPS MAIL please select format: ☐ CD/DVD ☐ Paper

IMPORTANT NOTE: If information contains sensitive information such as mental health/developmental disability, sexually transmitted diseases and/or alcohol/drug abuse, genetic testing or HIV/AIDS, or reproductive health then **Authorization to Use or Disclose Health Information** form must be completed. By law, we are not required to agree with your request for access to your PHI, and in certain situations, the law requires us to deny access. If this is the situation, we will advise you of the reason for the denial. Under certain circumstances, you may be able to request a review of the denial. If you request a copy of your records, OSF may charge a reasonable fee based on the cost of labor and materials to produce the copies.

_____ _____

Signature of Patient or Patient Representative ***Date***

_____

Signed by Patient Representative, state relationship to Patient and provide evidence of Authority to act for individual

_____ _____

OSF Employee filing out form ***Date***