



1ROI

PATIENT REQUEST TO ACCESS OR COPY PROTECTED HEALTH INFORMATION (PHI)

1. Mercy Facility(s) treated at: _____ MRN#: _____

2. Patient Name: _____ Date of Birth: _____

3. Requestor (if different): _____

4. Mailing address: _____

City: _____ State: _____ Zip code: _____

5. AM Phone number: () _____ PM Phone number: () _____

6. Do you wish to Access (read and review) () **OR** Receive a Copy ()

7. Describe the information you want to Access/Copy: _____

8. Date(s) of the information you want to Access/Copy: _____

There is no charge to access (read/review) your PHI or to supply you with a pertinent summary of your PHI. If you desire a copy of your entire record (PHI), the following charges apply: \$1.00 per page for pages 1-10, \$.50 per page for pages 11-50 and \$.20 per page for pages 51 or more. There will be a \$10.00 per film (e.g. x-ray) charge. We will inform you of the cost of your copy and verify you agree to pay for the PHI prior to copying. We will also include an invoice for any charges along with your copy. We will notify you in writing within 30 days of your request (60 days if the PHI is not maintained or accessible on-site) if and when your PHI will be available for access or where to pick up your copy. In exceptional circumstances, we will notify you within 30 days if we need one additional period of 30 days to respond to our request. In specific circumstances, we may deny access to your PHI or to a portion of your PHI. If we deny access, we will return this form to you with our written reasons for denying access and explain your review right if they apply.

Signature of Patient or Legal Representative

Date

If signed by Legal Representative, relationship to patient: _____
(Attach a copy of paper work verifying legal authority)

Date needed by: _____

MAIL

CALL FOR PICK UP

Photo ID is required when requesting and picking up PHI