Reeves Regional HEALTH

Request to Access Your Health Information

You have the right under HIPAA to request a copy of your health information (also called "PHI"). This includes medical records, billing information, and other documents used to make decisions about your care. However, this request **does not apply** to psychotherapy notes or records prepared for legal proceedings (e.g., lawsuits). Please complete this form to help us process your request.

SECTION 1—Individual Whose Records Are Being Requested

Full Name: _____ Date of Birth: _____

Preferred Contact Method:

☐ Phone #: _____ ☐ Email: _____

SECTION 2—What Information and Dates Are You Requesting?
Check the box(es) for the records you want. For each record type, tell us the date(s) you want. You can choose a date range or a specific date. If you're unsure, you can leave the date blank.

Information Type	Date(s) for This Record
☐ Clinic Notes	_____
☐ Immunization Records	_____
☐ Emergency Room Records	_____
☐ Lab Results	_____
☐ Radiology/Imaging (X-rays, MRIs, etc.)	_____
☐ Surgical/Medical History	_____
☐ Medication History	_____
☐ Billing and Insurance Information	_____
☐ Other (*describe*): _____	_____

SECTION 3—How Do You Want to Access and Receive Your Records? Choose how you'd like to access and receive your records. You may select more than one option. We will do our best to provide your records in the format and delivery method you prefer. If your chosen format isn't available, we will work with you to find an accessible alternative. You may also request a summary or explanation of your records.

☐ Electronic Copy—Choose your **preferred format** and **delivery method** below:

Format (*choose one*): ☐ PDF ☐ Word (.docx) ☐ Excel (.xls) ☐ QR (*imaging*) ☐ Other: _____

Delivery (*choose one*): ☐ Encrypted Email ☐ Fax ☐ CD/DVD ☐ Patient Portal ☐ Other: _____

☐ Paper Copy—Choose how you'd like to receive it:

- ☐ Pick up in office
- ☐ Mail to my address: _____

☐ View In-Person

SECTION 4—Do You Want to Send the Records to Someone Else?
Under HIPAA, you can request that your records be sent directly to someone else. This is a one-time request. Fill out the following information based on how you would like the records sent to the recipient:

☐ **Yes**, please send my records to the person below. ☐ **No**, I do not want my records sent to anyone else.

Recipient's Name: _____

Where to Send Records (Address or Email): _____

Relationship to You (*Optional*): _____

SECTION 5—Who Is Making This Request? Check one:

☐ Self (Your Records) ☐ Parent/Guardian ☐ Personal/Legal Representative

Proof of Identity (required):

☐ Driver's License or Government-issued ID ☐ Other (*specify*): _____

If you are a personal or legal representative, please attach documentation (e.g., court order, power of attorney) to support your authority to act on the individual's behalf, unless we already have the necessary supporting documentation on file in the individual's medical record.

SECTION 6—Acknowledgement

By signing below, I confirm the following:

- I understand my request will be processed within 30 days, unless state law requires it to be done sooner. I also understand that the processing time may be extended by up to 30 days, and I will be notified if this happens.
- If I asked to view my records, I understand that I may need to schedule an appointment.
- If I requested copies of my records, I understand there may be reasonable, cost-based fees for copies, postage, or storage media, and I can request an estimate in advance.
- If the format I requested isn't readily available, I will be provided with my records in an accessible format, or I may request a summary or explanation.
- I understand that in some cases my request may be denied, and I will be informed of the reason and whether I have the right to appeal.
- I authorize the disclosure of my records to the person listed in Section 4, if applicable.

_____ _____

Signature of Individual or Authorized Representative Date

_____ _____

Printed Name of Authorized Representative (*if not signed by the individual*) Relationship to Individual

Please submit completed request(s) to:
Clinic/Immunization Records - clinicmedicalrecords@Reevesregional.com
Hospital Records - medicalrecords@Reevesregional.com