



REQUEST FOR RELEASE OF PROTECTED HEALTHCARE INFORMATION

MAILING ADDRESS: 2302 COLLEGE AVE ATTN: HIM CONWAY, AR 72034 OFFICE: 501-450-2130 FAX: 501-450-2103 Please provide photo ID for all requests.

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

Phone Number: \_\_\_\_\_ Last Four Digits of Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

As the patient, or patient's personal representative, I am requesting a copy of the medical record held by Conway Regional Medical Center.

Date(s) of Service Requested: \_\_\_\_\_

Summary of: \_\_\_\_\_ Inpatient Visit \_\_\_\_\_ Outpatient Visit \_\_\_\_\_ Emergency Room Visit

\_\_\_\_\_ Radiology Report \_\_\_\_\_ Radiology Report & Disc

\_\_\_\_\_ Laboratory Report \_\_\_\_\_ Pathology Report

\_\_\_\_\_ Operative/Procedure Note \_\_\_\_\_ Device/Implants Stickers

\_\_\_\_\_ Other Information: \_\_\_\_\_

Please deliver to:

\_\_\_\_\_ Patient \_\_\_\_\_ In person \_\_\_\_\_ Mail to \_\_\_\_\_ \*Email \_\_\_\_\_ Email address above \_\_\_\_\_ (Unencrypted) \_\_\_\_\_ (Encrypted)

\_\_\_\_\_ Someone Other Than the Patient

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax Number: \_\_\_\_\_

I understand the medical record may include information relating to mental healthcare, communicable diseases, and treatment of alcohol or drug abuse. NOTICE: Once your PHI has been disclosed in accordance with this request, it may be re-disclosed to individuals or organizations that are not subject to the HIPAA regulations.

\*I have requested records by unsecure email and acknowledge the following potential risks:

- The information may be obtained by someone else.
The information can be opened and read by someone else.
Unencrypted information does not provide any assurance of privacy or security.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Representative, if not patient

\_\_\_\_\_  
Date