PATIENT RIGHT OF ACCESS FORM

*******Please Note: Reasonable charges MAY apply*******

Not to be used to request records from Marworth or Geisinger Behavioral Health Center Northeast

Patient Name: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____

Patient Phone Number: _____

Medical Record #: (if known) _____

I am requesting a copy of my Protected Health Information (PHI) in the Geisinger* Designated Record Set pursuant to the HIPAA Right of Access regulations. I am requesting records from the following entities:

☐ All Sites ☐ Specific Clinic(s) or Hospital(s) _____ .

Please produce records from the following dates: _____/_____/_____ to _____/_____/_____ ("present" equals date of signature).

SPECIFIC PHI TO RELEASE - (Check box of items to be released)

☐ Billing records*
☐ Clinic Visit
☐ Emergency Room visit
☐ HIV/AIDS
☐ Hospitalization records (admission)
  ☐ Discharge summary
  ☐ Consults
  ☐ Other: _____
☐ Immunization
☐ Medication Assisted Treatment clinic visit
☐ Medications
☐ Mental Health clinic visit
☐ Radiology/X-Ray Images*
☐ Radiology Reports
☐ Surgical (operative or pathology result)
☐ Test Results (specify Lab, EKG, EEG)
☐ Other: _____

METHOD OF DELIVERY: ☐ Mail ☐ MyChart Portal ☐ CD ☐ Email ☐ Fax

RECIPIENT

Name:	Phone Number:
Street Address:	Fax Number:
City, State, Zip:	Email Address:

IMPORTANT INFORMATION: I understand that if I ask Geisinger to disclose PHI to another individual or entity, that information may no longer be protected by Pennsylvania and Federal privacy laws, including HIPAA. I understand that Geisinger will make reasonable attempts to produce the documents in the format requested; however, if the records are not readily reproducible in that format, I understand Geisinger will contact me to discuss alternative delivery options. In certain limited circumstances, Geisinger may deny a request. If a request is denied, I understand I will be given a written explanation, and a description of steps I may take in response to the denial.

**Radiology/X-Ray images and billing records will be processed and delivered separately by those departments.*

SIGNATURES

NOTE: Signature of patient (14 or older) may authorize release of mental health information. Minors may authorize release of Drug & Alcohol treatment information as well as certain reproductive health treatment information.

Date/Time: _____ **Patient Signature**:_____

If patient is unable to sign authorization form because of physical condition or age, complete the following:

Patient is a minor or patient is unable to sign authorization because:_____

Date/Time: _____ **Signature**: _____

Description of personal representative's authority to act for the patient: _____

(Parent/legal or personal representative with authority under State law to make health care decisions for the patient.)

*Throughout this document, the term "Geisinger" shall refer to those corporate affiliates within the health care system which are involved in the provisions of health care services and related support services. Geisinger is comprised of Geisinger Health ("GH") as parent and all subsidiary corporate entities.