PeaceHealth

Request for Copy of Protected Health Information

You have a right under federal law to request a copy of your health information.

How to request a copy of your health information:

1. Complete the *Request for Copy of Protected Health Information* form.
   To prevent possible delays in processing your request, please carefully complete the form including:
   - Your complete address and phone number in case we need to contact you about your request.
   - The date by which you need the records in the section "Date records needed". For urgent requests, please call 360-729-1300.
   - If you are a parent, guardian or personal representative, please include your relationship to the patient in the section "Relationship to Patient" and provide the required documentation.
2. Return the request form using one of these methods:
   - **Email:** ReleaseofInfo@peacehealth.org
   - **Fax:** 360-527-9383 *(If you are completing this request at a PeaceHealth facility, you may ask a caregiver to fax the form on your behalf.)*
   - **Mail:** PeaceHealth, HIM Department, ROI Services
     1115 SE 164th Avenue, Dept.336
     Vancouver, WA 98683

What to expect after you have submitted a request form:

- Your request will be processed within 15 business days once it is received by the Health Information Management, Release of Information department in Vancouver, WA.
- If we are unable to process your request within 15 business days, we will contact you to let you know the reason for the delay and the anticipated processing date.

Receiving your records:

- You may choose to receive your health information by paper, electronically on a CD or via unencrypted or encrypted e-mail.
- PeaceHealth uses an e-mail encryption system to protect confidential e-mail messages. If you choose to receive your health information via encrypted e-mail, you will receive a notification e-mail containing a link to access the full message on our Secure E-mail Server. Directions will be provided in the email for you to create a user account to receive your information.
- Please note, unencrypted e-mail transmitted via the internet has a risk of being intercepted by unauthorized individuals.
- After 15 business days, if you have not received your records or been contacted, please check your email spam/junk folder.

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Request for Copy of Protected Health Information

Patient Information for Requested Records (***to prevent delays*, please print clearly and sign**):

Name: Last required	**First** required	**MI**
Street Address required		
City, State, Zip required	**Daytime Phone**	
Date of birth: required	**Evening Phone**	
Date records needed:	*Note: Most requests are sent within 15 business days.*	

What facility records needed? (check all that apply)

Location	Hospitals	PHMG
Springfield	❑ Riverbend Hospital	❑ Clinic
Eugene	❑ University District	❑ Clinic
Cottage Grove	❑ Cottage Grove Hosp	❑ Clinic
Florence	❑ Peace Harbor Hosp	❑ Clinic
Vancouver	❑ Southwest Hospital	❑ Clinic

Location	Hospitals	PHMG
Longview	❑ St John Hospital	❑ Clinic
Bellingham	❑ St Joseph	❑ Clinic
Friday Harbor	❑ Peace Island Hosp	❑ Clinic
Sedro-Woolley	❑ United General	❑ Clinic
Ketchikan	❑ Ketchikan Hosp	❑ Clinic

Other (Specify locations): _____

Send records to (Select one)

Send to the address listed above: ❑ Paper ❑ Electronically on CD

Send to this email: _____
❑ Encrypted (requires password authentication) ❑ Unencrypted (unsecure)

Recipient Address (unless same as above): ❑ Paper ❑ Electronically on CD
(Facility) Name: _____
Street Address: _____
City/State/Zip: _____

Send to this Fax number: _____
❑ **Send records to My PeaceHealth account**

❑ **Other delivery method (describe):** _____

Dates of service needed (Select one)

❑ Specific: (from) _____required_____ (to) _____required_____
❑ One-year history ❑ Other: _____

Information needed

❑ "Pert-Pack" (most requested) Includes: provider documentation, medication list and diagnostic information; Lab, X-ray, EKG
❑ Imaging Films ❑ Billing Records ❑ Other (specify): _____

Acknowledgements

1. I understand that I may be charged a reasonable, cost-based fee that covers the cost of copying, including supplies, labor, and postage.
2. If I choose to have my health information sent by unencrypted e-mail, I understand the inherent security risks associated with transmission of e-mail over the Internet.
3. I understand I must provide legal documentation if I am the guardian or Medical Power of Attorney.

Requester: (print your name here) Signature: _____ Date: _____

Relationship to Patient: ❑ Patient (self) ❑ Parent/*legal guardian ❑ *DPOA ❑ Other: _____

* Please attach proof of guardianship/DPOA (medical power of attorney) with this request.

How to return this completed form options:

Fax: 360-527-9383 | Email: releaseofinfo@peacehealth.org

Mail: PeaceHealth, HIM ROI
1115 SE 164th Ave, Dept 336
Vancouver, WA 98683

Questions? Call 360-729-1300

Staff use only: MRUN _____ Records provided? ❑ Yes ❑ No Initial _____ Date _____