Please allow up to 7 business days for WMC to process your request.

WRANGELL MEDICAL CENTER
310 BENNETT ST/PO BOX 1081
WRANGELL, ALASKA 99929

Incomplete forms cannot be processed.

PATIENT REQUEST FOR ACCESS TO THEIR PHI

This form is for patient requests to access (view,) receive, or send copies of their own medical information.

Printed Name of Patient:	Previous Names (if applicable):
Date of Birth (MM/DD/YYYY):	Daytime Telephone Number:
Printed name of personal representative and relationship to patient (if applicable):	
Physical address (for paper copies)**:**	**Email address** (for electronic copies)**:****
Street Address:	@
City:	***please be aware that email requests will be in pdf format*
State: Zip code:	**Fax number** (if applicable):

Information Requested:

_____ Medical Records from the last two years _____ Complete Legal Health Record

Date(s) of Service: __ /__ /____ through __ /__ /____

_____ Emergency Room Records _____ Discharge Summary _____Health Summary _____ Accounting of disclosures
_____ Physician Progress Notes _____ Nursing Notes _____ Billing records _____ Registration Records
_____ Test Results (Lab, Radiology Report, Pathology) *Please Specify*: _____
_____ Other (Immunization Record, Medication Lists) *Please Specify*: _____
_____ Other: _____

Please check all that apply to your request:

___ I am requesting access to review my medical information from Wrangell Medical Center (WMC) in person. *Please note, an appointment will be made for you to review your records with the HIM Director.* Your appointment is on _____ at _____

___ I am requesting paper copies of my WMC medical information to be (check one):
____ picked up by me
____ mailed to me (at address above)
____ faxed to me (at number above)

___ I am requesting electronic copies of my WMC medical information to be emailed to me (at email address above)

Please note: any medical information sent via unsecured email is inherently not secure and could result in the information being read or otherwise accessed while in transit. Please let WMC know if you do not wish to be sent your information via email.

Sign: (Patient name) _____ Date: _____

Sign: (Personal Representative) _____ Date: _____

ID # _____

Wrangell Medical Center recognizes a patient's right under HIPAA to access copies of his/her health information.
Please note that there may be a fee associated with processing a request and producing requested records.

For Facility Use:

Date Received:	Date Released:	MR #:	Acct #:	ROI #:	Released by: