WAVERLYHEALTH
CENTER
312 Ninth Street SW – Waverly, Iowa 50677
(319) 352-4120 – www.WaverlyHealthCenter.org

REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

Patient Name: _____
Last First MI Previous Name (if, applicable)

Date of Birth: _____

I request that Waverly Health Center provide me with access to my Protected Health Information (PHI) checked below:

☐ Most recent History and Physical ☐ Most recent discharge summary ☐ Most recent Emergency Room report

☐ Laboratory (specify type or date) _____

☐ Test results (i.e. EKG, PFT, etc. specify type and date) _____

☐ X-ray and imaging reports and/or films (specify type or date) _____

☐ Clinic records (specify clinic and date) _____

☐ Billing info (specify date) _____

☐ Other _____

Type of Access Requested

☐ Electronic copies E-mail address, if applicable _____

To protect the confidentiality of your PHI, it will be sent in an encrypted e-mail. If you want your PHI sent in an un-encrypted e-mail and you understand and accept the risk of your PHI sent in this unprotected manner please initial here: _____

☐ Paper copies

☐ I will pick up the copies ☐ Mail the copies to: _____
_____
_____

☐ Inspection of my health information
Please contact Health Information Management at (319) 352-4120, extension 2001, to arrange a mutually convenient time.

_____ _____ _____
Signature of Patient or Patient's Authorized Representative **Date** **Time**

If signed by the patient's Representative, please PRINT the name and describe the relationship to the patient:

_____ _____
Name **Relationship**

Internal Use Only: **WHC Employees check the boxes**

☐ Approve access _____ ☐ Deny access _____ (HIM to send Notice of Denial of Request for Access)

Choose one method of delivery: ☐ In person ☐ Mail ☐ Encrypted Email ☐ Fax ☐ Other _____

☐ Un-encrypted email requested; requestor warned/accepts risk

☐ Identification verified upon release

Released by/department _____ Date/Time released _____