central peninsula hospital
250 Hospital Place, Soldotna, AK 99669
(907) 714-4404 * www.cpgh.org

PATIENT ACCESS TO MEDICAL RECORDS

CPH/HP recognizes an individual's right under HIPPA to access copies of his/her health information contained in the CPH Designated Record Set. There may be charges associated with processing a request and producing the requested records. Though HIPPA allows 30 days for processing, we will attempt to be prompt in filling your request. If we are unable to fill your request in 30 days, you will be contacted.

Patient Last Name	First Name	Middle Initial	
Other Name(s) Used	Date of Birth Verified ❐	Phone	
State ID # Verified ❐	E-mail (optional) Verified ❐	Last 4 of SSN# Verified ❐	
Mailing address	City	State	Zip

1. What records do you want: ❐ CPH ❐ HP ❐ BHV HLTH ❐ CPH clinic____________________

Dates of Service ____________________ through____________________

❐ Discharge summary ❐ History & Physical ❐ OP/Procedure Reports ❐ Emergency Room Records
❐ Clinic Records (specify clinic) ________________________________ ❐ X-ray Reports & Images
❐ Lab/Pathology ❐ Other (please specify): ____

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2. How would you like your records delivered?

❐ Mailed ❐ In-person pick-up ❐ MyChart Portal
❐ Fax *provide warning if not a secure fax. ❐ Other: ____________________________

❐ **WARNING GIVEN OF RISK USING UNSECURE FAX**

3. To whom do you want the information sent?

❐ **Self** *(No signature required. Fill out section #4 if information is different from patient information above)*

❐ **My personal representative** (Personal representative: individual authorized to make medical decisions on the patient's behalf. There should be some documentation of this relationship such as an advance directive, medical power of attorney, legal guardianship, etc.) *(No signature required. Fill out section #4.)*

❐ **Third Party, anyone other than Self or Representative** *(Fill out section #4 and #5. Patient or Representative signature is required.)*

4. Where do you want the information sent?

Recipient Name (please print)	Recipient Phone :
Recipient Mailing Address	Recipient Fax:

5. If we are sending records to someone other than the patient or the personal representative, the patient or personal representative must sign below:

Printed name of person signing (patient or personal representative)	Relationship (please mark) ❐ Self ❐ Parent ❐ Guardian ❐ POA
Signature of Patient or Personal Representative	Date

Signature of Third Party Picking Up Records: ______________________________ Date: ______________

Print name of staff member completing this form: ____

Please submit this completed form By Mail: CPH HIM Department 250 Hospital Place, Soldotna, AK 99669
By Fax: (907) 262-2753
By E-mail: medicalrecords@cpgh.org

ONCE DISCLOSURE IS COMPLETE SCAN TO MEDICAL RECORD - FORM VALID FOR ONE YEAR FROM DATE OF REQUEST OR SIGNATURE