Trinity Health

**REQUEST FOR PATIENT DIRECTED ACCESS TO PROTECTED HEALTH INFORMATION (PHI)**

Printed Patient's Name_____Phone (_____)_____-_____

Patient's Birthdate_____Email Address_____

Address_____ City_____ State_____ Zip_____

**DESCRIPTION OF MEDICAL RECORDS REQUESTED**

**Please select facility from which you are requesting records:**

- ☐ Trinity Health Ann Arbor
- ☐ Trinity Health Livingston

Other _____

List Date(s) of Treatment _____

_____

_____

Please select documents:

☐ Emergency Department Report
☐ Consultations
☐ Progress Notes
☐ Summary/Abstract Record Set
☐ Discharge Summary
☐ Operative/Procedure Report
☐ Test Results (EKG, EEG, echo)
Specify Test Result_____
☐ History and Physical
☐ Lab/Pathology Results
☐ X-Ray/Diagnostic Results

☐ Clinic/Physician Office Notes Specify Provider Name_____

☐ Other (list) _____

Please include: ☐ Radiology Images/CD ☐ Itemized Billing Records ☐ Complete Medical Record (Fees may apply)

**PLEASE RELEASE MEDICAL RECORDS TO:**

I direct the medical records indicated above to be provided to the following:

☐ Patient/Myself ☐ Personal Representative ☐ Other, specify below:

Name_____

Address _____

Phone_____ Fax_____

**FORMAT REQUESTED:**(check only one option)

☐ Patient Portal/MyChart ☐ CD ☐ Paper ☐ Inspect a copy ☐ Email If you choose email, insert email address and choose secured or unsecured below Email address _____
☐ secured/encrypted email ☐ unsecured/unencrypted email *

*If you checked "unsecured email" please be aware that sending and receiving your medical record info via unsecured email creates personal risk of interception and potential identity theft. *Please initial if you are requesting unsecured delivery via your personal email listed above. Initials_____

**If records are unable to be emailed due to size limitations, please select an alternate format: ☐ Paper or ☐ CD

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**Charges for Access**: We will not charge you for your first copy of your pertinent record set and/or outpatient diagnostic test results**.** If you ask us to copy your complete medical record, we may charge a reasonable fee as permitted by HIPAA Privacy regulations. Health Information Management utilizes a copy service to complete most record requests. You may be invoiced directly by the copy service where applicable. You may request to be notified of any charges for approval prior to having your records sent to you.

**Information About Your Access Rights:** Except under limited circumstances, we will provide you with access to your records. We will respond to your request within 30 days (or 60 days if the extra time is needed to gather records) from the time we receive this completed form. In certain situations, we may deny your request but if we do, we will tell you in writing of the reasons for the denial and explain your rights to having the denial reviewed.

**I hereby request access to my health information as noted above maintained by Trinity Health Ann Arbor and/or Trinity Health Livingston. I understand that the release of my health information MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, treatment for alcohol and/or drug abuse, and/or genetic testing.**

**Please initial below to authorize the release of any of this information**

_____Alcohol/Drug Abuse or Addiction Diagnosis Treatment

_____Behavioral/Mental Health Information

_____Communicable Disease, including Sexually Transmitted Disease

_____HIV/AIDS Related Information, including testing and treatment

_____Genetic Testing

_____State Specific Regulations to authorize (customize by ministry if applicable)

**SIGN HERE**_____

Signature of Patient or Personal Representative Date

Printed name of patient's Personal Representative, if applicable _____

Describe Relationship to patient (e.g. minor's parent, guardian) _____

**Mail request form to:**
Trinity Health Ann Arbor
5301 McAuley Drive
Ypsilanti, MI 48197

REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON: If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request these records. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavits of Heir at Law, etc.

Trinity Health

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| RELEASE<br>**Request for Patient Directed Access to PHI** | NAME<br>DOB<br>MRN |