Compass Health Network

Solicitud del Paciente para Acceder a Información de Salud Protegida ("PHI")

Solicito mi PHI de la Facultad a continuación: _____

Nombre del Paciente: _____ **Fecha Nac.**_____ **Cliente #**_____

Dirección del Paciente: _____

Número Telefónico del Paciente: _____

Solicito una copia del siguiente PHI: *(por favor marque los casilleros a continuación)*

☐ Tratamiento/Plan de Salud	☐ Evaluaciones Psicológicas	☐ Evaluaciones Psiquiátricas
☐ Resumen del Alta	☐ Reportes de Laboratorio	☐ Historial/Físico
☐ Reportes de Consulta	☐ Notas de Progreso	☐ Estados de Cuenta
☐ Otros *(especificar)*		

echa **(s)de Servicio o PHI Solicitado: G** _____ **: OM** _____ **:** _____

(si las fechas no son especificadas, los archivos de todas las fechas de servicio ser n proporcionados)

IMPORTANT : onfirmo que esta solicitud de informaci n uede contener informaci n con relaci n a uso de drogas/alcohol, tratamiento de salud mental, informaci n gen tica, enfermedades de transmisi n sexual, estudios o tratamiento de VIH/SIDA o cualquier otra informaci n delicada

PHI especificado anteriormente sea proporcionado:

☐

☐ /entidad: r _____

(Specify name and address of person/entity to whom you would like your PHI to be sent)

I request that PHI be provided in the following format (if readily reproducible in this format):

☐ Paper Copy

☐ Electronic Copy via

☐ PDF Attachment to E-Mail

☐ Other: _____

I request that access to PHI be provided by the following method:

☐ Personal pick-up at above specified facility by me ☐

☐ Personal pick-up at above specified facility by

(specify name and relationship to patient): _____

☐ Mailed to the following address: _____

☐ Emailed by **Secure Mail** to the following e-mail address: _____

☐ Emailed by **Unsecure Mail** to the following e-mail address: _____

☐ Faxed to the following fax number: _____

☐ Other: *(specify)* _____

Patient's Name:_____ **Date of Birth:** _____ **Client #:**_____

ACKNOWLEDGMENT: I understand that unsecure/unencrypted e-mail is not secure and while in transit it can be intercepted and seen by others. By requesting to receive my PHI electronically I acknowledge that I understand and accept these risks.

Printed Name: _____

Signature:_____

Date:_____

Access Requested By: *(Check One)*

☐ Patient ☐ Parent (for minors) ☐ Personal Representative

If this request is signed by the patient's personal representative:
Please specify your authority to act on behalf of the patient and attach supporting documentation:

_____

Acknowledgment of Personal Pick Up:

Records picked up by (name/signature)_____Date: _____

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INTERNAL USE ONLY

Identity Verification:

Verification via Photo ID: ☐ Yes ☐ No

Verification via Matching Signature: ☐ Yes ☐No

Other: *(specify)* _____

Authority Verification:

Personal representative documentation provided and checked: ☐ Yes ☐ No

Request: ☐ Approved ☐ Denied (reason:_____)

Processed by:_____Date: _____