

**Request to Access
Protected Health Information Form**

You have the right to inspect and/or obtain a copy of most of your Protected Health Information (PHI) maintained in our possession. If you request copies of your PHI, we will notify you if there will be any charges to process your request.

Indicate the facility(ies) you are requesting records from:

- | | |
|---|--|
| <input type="checkbox"/> Kapi'olani Medical Center for Women & Children
1319 Punahou Street, Honolulu, HI 96826
Phone: 808-983-8610 Fax: 808-983-8210 | <input type="checkbox"/> Kapi'olani Women's Center, Artesian Plaza
1907 South Beretania Street, Honolulu, HI 96826
Phone: 808-983-8610 Fax: 808-983-8210 |
| <input type="checkbox"/> Pali Momi Medical Center
98-1079 Moanalua Road, Aiea, HI 96701
Phone: 808-485-4181 Fax: 808-485-4372 | <input type="checkbox"/> Straub Medical Center
888 S. King Street, Honolulu, HI 96813
Phone: 808-522-4285 Fax: 808-522-3207 |
| <input type="checkbox"/> Wilcox Medical Center
3-3420 Kuhio Highway, Lihue HI 96766
Phone: 808-245-1128 Fax: 808-245-1058 | <input type="checkbox"/> Kaua'i Medical Clinic
3-3420B Kuhio Highway, Lihue HI 96766
Phone: 808-245-1128 Fax: 808-245-1058 |

Patient Information: (Individual whose information is being requested)

Date of Request: ___/___/___		MRN:
Last Name:		First Name:
Middle Name or Initial:	Other Names Known By:	
Date of Birth: ___/___/___	Last 4 digits of SSN: XXX-XX-	
Street Address:		
City:	State:	Zip Code:
Email:	Phone (include area code):	

Please indicate what information is being requested:

Copies of all records for services provided for the period of ___/___/___ to ___/___/___ OR:

<input type="checkbox"/> Copies of the following for services provided for the period of ___/___/___ to ___/___/___		
<input type="checkbox"/> History & Physical Exams (Clinic)	<input type="checkbox"/> Hospital Progress Notes	<input type="checkbox"/> Clinic Visit Notes
<input type="checkbox"/> History & Physical Exam (Hospital)	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Laboratory Tests Results
<input type="checkbox"/> Imaging Study Reports	<input type="checkbox"/> ER Records	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Surgery Report	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Billing Reports
<input type="checkbox"/> Copies of Imaging Studies, Photographs, Videos, Digital Images (specify):		
<input type="checkbox"/> Other (describe):		

Patient: _____

Please indicate how you would like the information provided:

a. Format: USB CD E-mail Paper Other preferred form / format: _____

b. Delivery Method:

For pickup by (Name): _____ (individual will be asked for valid photo ID)

FAX to the following fax number (include area code): _____

Other: _____

E-mail to the following e-mail address: _____

E-mail and contents will be sent via secured method unless you indicate otherwise after reading the following statement:

I request delivery via unsecured means and understand unsecured emails/text messages can be intercepted, forwarded, printed, and stored in multiple locations; sent to the wrong address; altered or used without detection; spread computer viruses; may exist even after being deleted by both parties; and service providers have a right to archive and inspect email content. Please reply that you understand and are willing to accept these risks.

INITIAL here if you agree to accept the risk of delivery by unsecured means: _____

Mail to the following: _____
Person or entity

Street City State Zip Code

Print name of person requesting access: _____

If you are not the patient, what is your relationship to Patient? _____

Signature: _____ Date: _____

If you are a personal or authorized representative (other than a parent of a minor child), you will need to provide documentation or an explanation of your authority to act for the patient (e.g., Health Care Power of Attorney, signed and completed authorization form). Authorized representatives may also be asked to provide proof of identification.

For Facility use only

Verbal Request by Patient/Patient Representative.

If unsecured email requested during Verbal Request, risk acceptance statement was read to Patient and Patient verbally expressed understanding and acceptance of the risk.

ID Check/Source: _____ Released By: _____ Date: _____

Comments: