I ____ hereby request access to view my Protected Health Information which is maintained at Magee-Womens Hospital or at Magee Womancare Associates.

PATIENT IDENTIFICATION:

DOB:____________________ SSN:______________________________

Street Address:____ City:_________________________

State:________ Zip:________________ Daytime Phone:____

May we have your permission to leave a message at the number you provided in regard to this request?

Yes____ No____ Specific limitations:____

I would like to review the following records:

____ Inpatient Records; Dates:____

____ Outpatient Records; Dates:____

____ Emergency Room Records; Dates____

____ Physician Office/Clinic Records; Dates:____

____ I would like copies of the above records and agree to the related charges as identified on the attached table.

____ _________________________

Patient Signature Date

The above named patient is unable to provide a signature due to:_____________________________________

____

Parent/Legal Guardian/Personal Representative

Signature:____ Date:_______________________

Relationship to Patient AND Description of authority to act on behalf of:

____

*** ORAL AUTHORIZATION ***

Witness #1:____ Date:_______________________

Witness #2:____ Date:_______________________

(Two witnesses are required if patient is giving verbal authorization (not applicable to HIV related information) or signs by making an “X”.)

ADDRESSOGRAPH

Magee-Womens Hospital
of UPMC Health System

PATIENT REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

71437-0043PS Rev. 3/03

FOR INTERNAL USE ONLY

____ Access Granted

____ Access Denied

If denied must specify reason and whether denial is reviewable or unreviewable:

____

____

Staff Level required to be present during viewing (to be determined by physician):

____ Clerk (cannot answer any patient questions); ____ RN ____ PA ____ Resident ____ MD

Signature of Authorizing Physician (if applicable):____

Access Granted ---- Date Patient Notified:________________ via: ____ letter ____ phone message left? ____ Yes ____ No

Date Notification Letter Sent:_______________ Signature of Notifier:______________________________

Date Reviewed:______________ Signature of Staff member present for review:______________________

Fee collected - Amount:______________ Method of payment: ____ Cash ____ Check (Check Number):__________

PATIENT ACCESS FEE TABLE

COPIES OF PHI	CHARGE
Search and Retrieval of Records	Not Applicable
Amount charged per page for pages 1 - 20	$1.11
Amount charged per page for pages 21 - 60	$.84
Amount charged per page for pages 61 - end	$.29
Amount charged per page for microfilm copies	$1.65
Cost of postage, shipping and delivery of requested PHI	Actual cost
SCHEDULED REVIEW OF PHI WITH PATIENT	**CHARGE**
Review of chart - during patient hospitalization	Fee waived
Review with HIM Clerk or HIM Designee (clerk unable to answer questions)	No charge permitted
Licensed Professional (may be able to answer certain questions)	$25 per 15 minute increments (e.g. one 15 minute increment would be $25, 16-30 minutes would be $50, etc)
Physician	$50 per 15 minute increments (e.g. one 15 minute increment would be $50, 16-30 minutes would be $100, etc)
Written Summary - Dictated by Physician	$25 plus $5 transcription fees