CONWAY REGIONAL HEALTH SYSTEM

# REQUEST FOR RELEASE OF PROTECTED HEALTHCARE INFORMATION

**MAILING ADDRESS:**
**200 North 3rd Street ATTN: HIM**
**Dardanelle, AR 72834**
**OFFICE: 479-229-4677**
**FAX: 479-229-6176**
**Please provide photo ID for all requests.**

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Last Four Digits of Social Security Number: _____

Address: _____

Email Address: _____

**As the patient, or patient's personal representative, I am requesting a copy of the medical record held by Conway Regional Medical Center.**

**Date(s) of Service Requested:** _____

Summary of: _____ Inpatient Visit _____ Outpatient Visit _____ Emergency Room Visit

_____ Radiology Report _____ Radiology Report & Disc

_____ Laboratory Report _____ Pathology Report

_____ Operative/Procedure Note _____ Device/Implants Stickers

_____ Other Information: _____

**Please deliver to:**

| | | Mail to | *Email | Email |
|---|---|---|---|---|
| _____ Patient | _____ In person | _____ address above | _____ (Unencrypted) | _____(Encrypted) |

_____ Someone Other Than the Patient

Name: _____

Address: _____

Phone/Fax Number: _____

I understand the medical record may include information relating to mental healthcare, communicable diseases, and treatment of alcohol or drug abuse. **NOTICE:** Once your PHI has been disclosed in accordance with this request, it may be re-disclosed to individuals or organizations that are not subject to the HIPAA regulations.

*I have requested records by unsecure email and acknowledge the following potential risks:

- The information may be obtained by someone else.
- The information can be opened and read by someone else.
- Unencrypted information does not provide any assurance of privacy or security.

_____ _____

Patient Signature Date

_____ _____

Legal Representative, if not patient Date