Kiowa County Memorial Hospital Operated Under Lease by GPKC, Inc..
721 W Kansas Ave
Greensburg, Ks 67054-0616
Telephone 620 723 3341 Fax 620 723 2195

REQUEST TO INSPECT OR COPY HEALTH INFORMATION

Please submit this request to our Privacy Officer/Contact Person. If you have any questions, comments or complaints, or would like to review or obtain a copy of our Notice of Privacy Practices, please contact:

Privacy Officer
721 W Kansas
Greensburg, KS 67054
Telephone: 620 723 3341

PATIENT HEALTH INFORMATION REQUESTED:

Patient name:_____ Date(s) of Treatment:
Address:_____
Telephone:____-____-____ Date of Birth:____/____/____ Social Security Number:____-____-____

RECORDS REQUESTED:

Please specify the records you wish to inspect or obtain copies of (please include date(s) of treatment to help us process your request):

__UB-92 (837-I) _____
__HCFA 1500 (837-P) or (837-D) _____
__Detail bill _____
__Advance directives _____
__Amendments _____
__Anesthesia records _____
__Assessments (i.e, nursing, MDS, OASIS, etc.) _____
__Care plan _____
__Consent for treatment forms _____
__Consultation reports _____
__Diagnostic study results (e.g., laboratory, radiology, pathology, etc.) _____
__Discharge instructions _____
__Discharge/narrative summary _____
__E-mail containing patient-provider or provider-provider communication _____
__Emergency department record _____
__Graphic records _____
__Immunization record _____
__Intake/output records _____
__Medication records _____
__Multi-disciplinary progress notes/documentation _____
__Notes _____
__Operative and procedure reports _____
__Orders _____
__Patient-submitted correspondence, documentation _____
__Practice guidelines or protocols/clinical pathways that embed patient data _____
__Problem list _____
__Procedure reports _____
__Records of history and physical examination _____
__Source data: _____
(a) analog and digital patient photographs for identification purposes only
(b) diagnostic films and other diagnostic images
(c) electrocardiogram tracings
(d) fetal monitoring strips
__Therapy/rehabilitation records (i.e., occupational, physical, respiratory, speech) _____
__Treatment related correspondence _____
__Videos/photographs _____

Please specify the type of access you request (e.g., inspection or copying):_____

Where may we contact you with questions about this request or to set up a time to inspect the records if requested (include address, phone number and best time to call):

_____

_____

_____

Please indicate method of delivery if copies are requested:

__I will pick up the records from the Hospital.
__Please fax. My fax number is _____.
__Please mail the records to the following address (Please note that we can only send records to the patient whose medical information is being requested. All other requests must be made through an Authorization): _____

_____

I request access to the health information and records indicated on this form as set forth above. I certify that the records sought are my own or that I am the personal representative of the patient whose records are sought and am authorized to make this request.

_____ _____

Signature of Patient or Patient's Personal Representative **Date**

Personal Representative's Relationship to Patient:_____

(PROVIDE THE PATIENT A COPY OF THIS FORM UPON COMPLETION)