Patient Number:__________

BELMONT PINES
HOSPITAL

615 Churchill-Hubbard Road
Youngstown, Ohio 44505
Phone: 330-759-2700
Fax: 330-759-1120

Request for Access to Patient Health Information

As a patient of Belmont Pines Hospital, you are entitled under federal law to access your personal health information maintained in a "designated record set". In order to process your request for access to this information, please complete this form and submit it to the Medical Records Department. When received by Medical Records, the information will be used to verify your identity and process your request. If you have any questions or concerns, please contact us at 330-759-2700, ext. 7932.

Patient Information

Patient Name:______________________________________ Date of Birth:__________________________

Person Requesting Information:_______________________ Date of Request:________________________

Relationship to Patient:______________________________ Phone No.:_____________________________

Reason for Request:____

____

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____

Information Being Requested - Please write specifically the information you are requesting to access **(please see the attached medical record list)**:____

____

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Access Method

You have the right to view your protected health information, obtain a copy of the information, or both. Please indicate below whether you wish to view the information only, obtain a copy, or both. If you select "copy", please indicate your method of delivery.

- ☐ I would like to **VIEW** my protected health information. I have/will schedule(d) an appointment with Belmont Pines Hospital to view my health information on:_____________________________________
  ____

  I understand Belmont Pines Hospital may have a staff member sit down with me as I review my health information.
- ☐ I would like a **COPY** of my protected health information. I understand that Belmont Pines Hospital will charge me a fee for the copies (including faxed copies) according to relevant state law. I also understand that I will be required to pay the fee in full before I can obtain the copy. I have selected my delivery method below (if none is selected, I will pick up the copy at the practice):
  - ☐ I will return to Belmont Pines Hospital and pick up the copy when it is ready.
  - ☐ I would like Belmont Pines Hospital to send the copy via U.S. Mail to the following address:____
    ____
    ____
    ____
  - ☐ I would like Belmont Pines Hospital to send the copy via facsimile to the following number:____
    ____
  - ☐ If possible, I would like my copy sent to me electronically using the following format:_________
    ____

    If Belmont Pines Hospital cannot readily produce the information in the form or format you have requested, such information will be made available to you in a readable hard copy form or other form or format agreed to.

I understand that Belmont Pines Hospital is given thirty days to process my request for access if my information is maintained on-site, sixty days if the information is maintained off-site, and that Belmont Pines Hospital may extend the deadline by an additional thirty days if I am notified in writing of the extension. I further understand that my rights are limited to any information in my medical record as compiled by Belmont Pines Hospital.

By signing below, I acknowledge and agree to the above conditions.

_________________________________	__________________________	____________________
(Patient signature if 12 years or older)	**(Print Name)**	**(Date)**
_________________________________	__________________________	____________________
(Parent/Legal Guardian Signature)	**(Print Name)**	**(Date)**
_________________________________		
(Relationship to Patient)		

Patient Number:__________

Office Use Only

Request received on__________________________by__________________________________

Request reviewed by:____________________________________

Request has been:

- ☐ Accepted in full
- ☐ Accepted in part
- ☐ Denied

____________________________________ ________________________
Physician's Signature Date

Letter indicating decision mailed to patient on_______________________.

If patient was given access <u>in full</u>, complete the information below:

The record was:

- ☐ Viewed by the patient on______________________.
  Staff member who assisted the patient in viewing the requested information:
  ____

Copied on________________. Total cost for copies $_________________

- ☐ Picked up by patient on_____________________________________
- ☐ Mailed via U.S. Mail on____________________________________
- ☐ Sent to patient via________________on______________________
- ☐ Faxed to patient at fax number on___________________________

Cost for postage/shipping $_________________________________
The fees were received in full by ___________________________on______________________

If decision was accepted <u>in part</u>, complete the information below:
Indicate which part(s) have been denied and the reason(s) why:_______________________________________
____
____
____

Has patient asked for a review of the decision?

- ☐ Yes, letter asking for review received on _________________________________

Decision reviewed on ________________________by__________________________________

Reviewing official's decision:

☐ Affirm decision ☐ Overturn decision (complete the disclosure information above).

Patient notified of reviewing official's decision in letter/fax sent on ________________________

If denied, complete the information below:

Indicate why the request has been denied (be specific): ____
____
____
____

Has patient asked for a review of the decision?

- ☐ Yes, letter asking for review received on ____________________________

Decision reviewed on ______________________________________

Reviewing official____

Reviewing official's decision:

- ☐ Affirm decision
- ☐ Overturn decision (if overturned, complete the disclosure information above).

Patient notified of reviewing official's decision in letter/fax sent on _________________________

Comments of Healthcare Practitioner or Reviewer:
____
____
____
____
____

_____________________________________ _________________________
Physician's Signature Date

Medical Record List

On page 1 you are asked to specifically write the item(s) you are requesting access to. Please select from the list below. Additionally, if you write "any and all medical records", the request will be returned to you so that the specific item(s) can be written.
If you have any questions, please do not hesitate to call the Medical Records department for further assistance at 330-759-2700 and have me (Robyn) paged. Please do not leave a VM.

	Inpatient & Partial Hospitalization Charts	**Approx. # of pages**
	Discharge Summary	4-10
	Psychiatric Evaluation	3-9
	Treatment Plan	5-8
	Laboratory Data	1-6 (if any)
	Consultation Reports	1-4 (if any)
	History & Physical Exam	5
	Psychological Testing	3-6 (if any)
	Physician Progress Notes	7-10
	Transitional Care Plan (MDA)	1-4
	Outpatient Charts	**Approx. # of pages**
	Psychiatric Evaluation	3-9
	Mental Health Assessment	5-6
	Physician Progress Notes	1 for each visit w/ doctor
	Treatment Plan	5-8

FEE SCHEDULE

The following fees are from the Ohio Department of Health (ODH) that specifies what hospitals and companies can charge for copying medical records in 2020.

These fees are based on Ohio Revised Code 3701.741 and adjusted by ODH per ORC 3701.742 according to the annual consumer price index for all urban areas for the preceding year as published by the U.S. Department of Labor.

- **For requests made by patients or their representatives,** hospitals may charge:

$3.31 per page for the first 10 pages,
69 cents per page for pages 11-50,
28 cents per page for pages 51 and over.

With respect to data resulting from an X-ray, MRI or CAT scan, recorded on paper or film:
$2.27 per page.

The actual cost of postage may be charged.

- **For requests made by someone other than the patient or patient's representative,** hospitals may now charge:

An initial fee of $20.42 to compensate for the records search.
$1.34 per page for the first 10 pages,
69 cents per page for pages 11-50,
27 cents per page for pages 51 and over.