WAVERLYHEALTH
CENTER
312 Ninth Street SW – Waverly, Iowa 50677
(319) 352-4930 – www.WaverlyHealthCenter.org

REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

Patient Name: _____ _____
Last First MI Previous Name Date of Birth

I am requesting my records be sent to:

_____
Name of person and/or facility

_____ _____ _____ _____
Street Address City State Zip

_____
Phone Number Fax Number

Type of Records to Send:

_____

_____

2-year history unless otherwise specified: _____ to _____
(Month/year) (Month/year)

Type of Access Requested: ☐ Mail ☐ E-mail ☐ Fax (limited 40 pages)

☐ Secure email: _____
Provide E-mail address

☐ If you want your records sent in an un-encrypted e-mail and you understand and accept the risk of your PHI sent in this unprotected manner, please initial here: _____ _____
Initial **Provide E-mail address**

☐ Mail the copies to: ☐ Self ☐ Other (list name) :_____

Address/City/State/ZIP: _____

☐ Inspection of my health information – Please contact Health Information Management at (319) 352-4930, to arrange a mutually convenient time.

_____ _____
Signature of Patient or Patient's Authorized Representative **Date**

If signed by patient's representative, please PRINT representative's name and describe his/her authority.

_____ **Authority:** ☐ Parent of Minor ☐ Legal Guardian (Obtain Court document)
Representative's name ☐ Power of Attorney for Health Care (Obtain HCPOA document)
☐ Other _____

INTERNAL USE ONLY (Document PHI disclosed, date of disclosure and by whom)

_____

Released by/Department: _____ _____
Initials/Department Date/Time