Requesting Medical Records

To request a copy of your medical records from Princeton Community Hospital, you will need to complete the "Access Request Form" which is a valid HIPAA authorization.

Instructions how to complete the Access Request Form:

- Download the Access Request Form

You will need to read the entire form and complete the following sections. If these yellow highlighted sections are not completed, your request can not be completed.

- Provide the Patient Name, Home Address, Telephone Number, and Date of Birth
- Check the appropriate line for the requests: either for yourself or complete for another designation such as your physician
- Specify the date(s) of treatment you want copied
- Check the categories of documents you need
- The special consent by law section must be checked if you need these documents
- Check the reason(s) for requesting the information
- Sign and date the document (No electronic signature will be accepted.)

You may call our ROI staff at 304-487-7521 or 304-487-7257 if you have questions in completing this form.

If you are not the patient, you must document your relationship to the patient. If you are the MPOA, Guardian, Custody, Executor of Estate, etc., we must have a copy of the respective document.

You may return the completed Access Request Form by:

- Mailing to Medical Records Department, Princeton Community Hospital, 122 12th Street PO Box 1369, Princeton, WV 24740
- E-mailing to ROI@pchonline.org
- Faxing to 304-487-7549 or 304-487-7179
- Hand delivering to Medical Records Department Monday-Friday, 8:00 a.m.-4:30 p.m.

We will complete and forward the requested information to you within 30 days by:

- Mailing to the address you provided on the form
- Downloading to CD must be picked up in the Medical Records Department
- Secured E-mailing to e-mail address provided on the mailing address line. Receiving your records through e-mail will require you to establish an account with Barracuda before opening the e-mail.

There will be no charge providing you request minimal documents.

PRINCETON Community Hospital

ADDRESSOGRAPH

ACCESS REQUEST FORM

Patient Name_____
Last First Middle

Home Address_____
Street, Route, or P.O. Box City State Zip Code

Home Phone (____)_____ Date of Birth_____
Month Date Year

____I am requesting a copy of my Medical Records

OR

____I am requesting that my health information be sent/given to:

Organization Name/Individual_____

Mailing Address_____

Phone Number_____Fax Number_____

Information needed by (date)_____.

Information to be Released- Important- Indicate only the information that you are authorizing to be released.

____Specific dates of treatment_____

OR

___ All health information _____

Check to release specific portions of your health information, indicate the categories to be released:

___History/Physical	___Mental health	___HIV/AIDS testing
___Laboratory Reports	___Discharge Summary	___Radiology Reports
___Emergency Room Report	___Progress Notes	___Radiology images
___Surgical Report	___Consultations	___Photographs, video, digital/other images
___Medications	___Immunizations	___Drug/Alcohol Records
___Billing records	___Pathology	___Cardiopulmonary

___Other information or instructions_____

The following information requires special consent by law. Even if you indicated all health information, you must specifically request the following information in order for it to be released:

___Chemical dependency program ___Psychotherapy notes

Reason(s) for releasing formation

___Patient's request	___Payment	___Treatment/continued care
___Legal	___Insurance application	___Other_____ Please specify

I request my records be provided to me:
____ on paper— in person
____ mailed to my home address
____downloaded to CD – must be picked up in person in Medical Records Department
____ e-mailed to my e-mail address:_____

I understand that once Princeton Community Hospital (PCH) discloses my health information to the recipient, PCH cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable Federal and West Virginia law governing the use and disclose of my health information.

I may stop this consent at any time by writing to PCH. If PCH has already released the health information based on my consent, my request to stop will not be valid for that health information.

This authorization is valid for one release only to the individual you have identified. This authorization is valid for the date signed below only. This authorization is for past dates of service only. You may not authorize a release for a date of service which has not yet occurred.

I understand that Princeton Community Hospital may charge a fee based on the cost of fulfilling this request. A mailing fee may be applied if necessary. Copy fees may change to comply with regulatory guidelines.

_____ _____
Signature of Patient or Personal Representative Date

_____
Print name of Personal Representative Relationship to Patient

OFFICE USE ONLY

Date Information Released_____

MR#_____ A/C#_____

Staff member releasing information_____

Identification of Requestor Verified By:

___Driver's License ___ Gov. Photo ID ___Signature of Record ___Legal Documents

___Provided copy of signed Authorization to Patient