

## REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION BY INDIVIDUAL PATIENTS

Please check (✓) the appropriate box(es) (□) and fill in the blank(s) as needed.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                 |                                                                                                                                                                                          |                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                 |                                                                                                                                                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>1. Patient Information:</b><br>Name ( <i>Last, First, MI</i> ) _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                 |                                                                                                                                                                                          |                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                 |                                                                                                                                                                                          |
| Date of Birth _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Last 4 Digits of SSN _____                                                                                                                                                                                                      | Phone Number _____                                                                                                                                                                       |                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                 |                                                                                                                                                                                          |
| <b>2. Requesting Information From:</b> ( <i>specify TGH/TGMG location</i> ) _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                 |                                                                                                                                                                                          |                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                 |                                                                                                                                                                                          |
| <b>3. Date(s) of Treatment:</b> <input type="checkbox"/> Specific Dates: _____ through _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                 |                                                                                                                                                                                          |                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                 |                                                                                                                                                                                          |
| <b>4. Please Check Specific Information Requested:</b> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Abstract Report (<i>all pertinent information</i>)<br/> <input type="checkbox"/> Discharge Summary<br/> <input type="checkbox"/> History and Physical<br/> <input type="checkbox"/> Operative Report<br/> <input type="checkbox"/> Laboratory Reports         </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Entire Report<br/> <input type="checkbox"/> Radiology Reports<br/> <input type="checkbox"/> Cardiology Reports<br/> <input type="checkbox"/> Progress Notes<br/> <input type="checkbox"/> Consultation Reports         </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Emergency Room Report<br/> <input type="checkbox"/> Radiology Images/CD<br/> <input type="checkbox"/> Cardiology Images/CD<br/> <input type="checkbox"/> Other: _____         </td> </tr> </table> |                                                                                                                                                                                                                                 |                                                                                                                                                                                          | <input type="checkbox"/> Abstract Report ( <i>all pertinent information</i> )<br><input type="checkbox"/> Discharge Summary<br><input type="checkbox"/> History and Physical<br><input type="checkbox"/> Operative Report<br><input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Entire Report<br><input type="checkbox"/> Radiology Reports<br><input type="checkbox"/> Cardiology Reports<br><input type="checkbox"/> Progress Notes<br><input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Emergency Room Report<br><input type="checkbox"/> Radiology Images/CD<br><input type="checkbox"/> Cardiology Images/CD<br><input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Abstract Report ( <i>all pertinent information</i> )<br><input type="checkbox"/> Discharge Summary<br><input type="checkbox"/> History and Physical<br><input type="checkbox"/> Operative Report<br><input type="checkbox"/> Laboratory Reports                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> Entire Report<br><input type="checkbox"/> Radiology Reports<br><input type="checkbox"/> Cardiology Reports<br><input type="checkbox"/> Progress Notes<br><input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Emergency Room Report<br><input type="checkbox"/> Radiology Images/CD<br><input type="checkbox"/> Cardiology Images/CD<br><input type="checkbox"/> Other: _____ |                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                 |                                                                                                                                                                                          |
| <b>5. In what format would you like to receive your records (choose one):</b><br><input type="checkbox"/> Paper <input checked="" type="checkbox"/> CD <input checked="" type="checkbox"/> Email <input type="checkbox"/> MyChart ( <i>patient or proxy only/must have active account</i> )<br><input type="checkbox"/> Access to Review ( <i>by appointment only/ROI business hours</i> )<br><input type="checkbox"/> Please send the copies of my records to:<br>Individual/Legal Guardian/Personal Representative Name: <u>Legal-Ease Digital Imaging, LLC</u><br>Street Address: <u>2496 Meadowcroft Dr</u><br>City, State, and Zip Code: <u>Burton, MI 48519</u><br>Phone Number of Individual Receiving Records if not Patient: <u>PH: 855-543-4003 FX: 810-547-4030</u><br>Email Address (please print clearly): <u>pat.legalease@gmail.com</u><br><b>Email is not a secure means of communication. We will encrypt email communications of your records.</b>                                                            |                                                                                                                                                                                                                                 |                                                                                                                                                                                          |                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                 |                                                                                                                                                                                          |

If I submit this access request form and request to have my information sent to a third party, I understand that information contained in my medical record may contain HIV/AIDS testing, results, and/or treatment records; mental health diagnosis and/or treatment records; alcohol and/or drug abuse diagnosis and/or treatment records.

### Processing Your Requested Information:

The Release of Information service area within the Health Information Management Department at Tampa General Hospital processes all requests for records for Tampa General Hospital, Tampa General Medical Group, the Ambulatory Surgery Centers at the TGH Brandon Healthplex and Morsani, and the TGH General Surgeons of the Palm Beaches.

We may charge a fee for copies of requested health information to cover cost of labor, supplies, and/or postage, if mailed to you. We will inform you of the total charges before providing the requested copies. We will respond to your request within 30 days from date of receipt. Actual turnaround time is typically shorter. We will require an additional 30-day extension if your health information is not readily accessible or is maintained in an offsite storage facility. We will notify you if we need this extension of time.

We appreciate your patience while we process your request.

\_\_\_\_\_  
Signature of Patient/Legal Guardian/Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by Legal representative, Relationship to Patient



FAQ's on the reverse side

**1. How do I submit my request for medical records?**

Patients and their personal representatives can email, fax, or mail your request for medical records, radiology studies, and/or cardiology studies. If you have an active MyChart account, you can also submit a Chart Request Form from MyChart.

- a. Email: [roirequests@tgh.org](mailto:roirequests@tgh.org)
- b. Fax: (813) 844-1135 (dedicated fax line for patients)
- c. Mail: Tampa General Hospital  
Health Information Management/ROI  
PO Box 1289  
Tampa, FL 33601

**2. Once I request my medical records, how will I receive them?**

We can mail paper copies or electronic copies on CD to you, deliver them electronically via email, or deliver them electronically via your active MyChart account. Please specify when requesting.

**3. Can I receive my records via fax?**

No. Due to HIPAA rules and regulations, and to ensure every patient's right to privacy, we only fax patient medical records to other medical facilities for immediate patient care.

**4. Can I receive my records via email?**

Yes. There is a risk associated with transmitting protected health information through unencrypted email possibly resulting in unauthorized third parties intercepting the email.

**5. Who can I call regarding my records? Billing, Radiology, etc.?**

Release of Information (ROI) provides patients with CDs containing Radiology and/or cardiology imaging studies. Please call the Billing Department for requests and inquiries regarding billing information for services provided.

ROI: (813) 844-7533 Billing: (813) 844-7291

**6. What are the business hours for ROI?**

Customer Service phone lines are open Monday – Friday 9:00 a.m. to 12:00 p.m. and 1:00 p.m. to 4:30 p.m. We are closed on weekends and holidays.

**7. Is there a charge for copies of my medical records?**

Yes. Per Federal and State regulations, there may be a minimal fee associated with obtaining copies of your medical records depending on the format requested and amount of information. There is no charge for medical records if they are provided directly to your physician or to the patient through their MyChart account.

**8. Can I request my records in person and/or pick up my records?**

We are unable to accommodate walk up requests or in person pick-ups as we are not located onsite. We do have several options for you to submit your requests and receive your records that are more convenient. See FAQ #1 above.

**9. How long does it take to receive my records once my request is received?**

Once your request is received, it may take up to 30 days to process and be delivered to you. Electronic format via MyChart or email are the quicker options. Paper records or records on a CD mailed via the United States Postal Service (USPS) will take additional time. We do not have control over delays that may occur with records during transport and delivery by USPS. Some requests may take additional time depending on their accessibility. If we need additional time, we will inform you of the delay, which will be no longer than an additional 30 days.

**10. Who can request my records?**

Only you or the person/entity authorized by you to obtain records may request records. A Healthcare Surrogate or Power of Attorney appointed by you may request copies of your medical records. A copy of the corresponding documentation and appropriate identification must be presented before records will be released to a personal representative.

**11. Can I request records on a deceased person?**

Records on deceased patients can be requested by the Administrator of the deceased's estate, next-of-kin (surviving spouse, adult children, parents, or adult siblings, respectively). Proper documentation and identification must be provided. This may include court documentation, death certificate, and documentation proving relationship, i.e. an adult child requesting his/her deceased parent's records must provide proof that there is no surviving spouse and a birth certificate identifying patient as his/her parent.

**12. How do I request someone else's medical records?**

Only under certain circumstances can you request and receive someone else's medical records without their written authorization.

- You must be the parent of a minor child (under 18) who is not emancipated, or
- You must have Power of Attorney or Health Care Surrogate for the patient you are requesting, or
- You must provide a court order allowing you to obtain requested records.

**13. What is an abstract?**

An abstract is a summary of your visit that contains the pertinent information about your treatment. For a typical inpatient stay, an abstract could consist of a discharge summary or order, history and physical, consultations, operative reports, lab results, radiology reports, and any additional diagnostic testing results.