BE 21st Century Oncology / Urology Experts

PATIENT REQUEST FOR PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____
Name at time of Treatment (if different than above): _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____

What protected health information do you want? (Check appropriate boxes below):

Specific Treatment Dates: _____ to _____
☐Consultation Reports ☐Diagnostic Films ☐Dosimetry Records ☐Laboratory Results ☐Physician Dictation
☐Portal Films/Simulation Films ☐Progress Notes ☐Radiology or Imaging Reports ☐Surgery/Pathology
☐Complete Medical Record ☐Billing Records
☐Other (please specify): _____

How would you like your protected health information delivered?
☐Paper format: ☐CD/flash drive (*For paper/CD/flash drive select one*): ☐ Home Delivery ☐ In-person pickup
☐Secure Email ☐Unsecure email* ☐Portal ☐Other: _____

** Information delivered through email is inherently unsecure unless it is fully encrypted. Requesting that my records are sent to an unsecured email address is not a secure delivery method and there is risk that my health information may be intercepted and/or viewed by unauthorized persons. 21st Century Oncology and its affiliates, are not responsible for a third party's unauthorized access to my personal health information delivered in this format or any risks (e.g., virus) potentially introduced to my computer/device when receiving personal health information through unsecure email.*

I request that my protected health information (PHI) from 21st Century Oncology be sent to:
☐Self ☐Personal Representative (indicated address below)

Recipient Name: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____
Fax (healthcare provider only): _____

Patient/Authorized Representative
Signature*_____Date_____Time_____

Printed Name of Authorized Representative: _____

Relationship to Patient: _____

*If signed by a patient-authorized representative, supporting legal documentation must accompany this authorization form.

Driver's License or Photo ID (*required when records are picked up*) Driver's License State: _____Number: _____

_____**Date**_____**Time**_____
Witness Signature

Send completed form to: Urology Experts
4571 Colonial Blvd Suite 110
Fort Myers, FL 33966

21st Century Oncology recognizes a patients' right under HIPAA to access copies of his/her health information.
There may be charges associated with processing a request and producing requested record

Instructions for completing the Patient-Directed Request for Health Information:

1. Complete the first section with your current name, date of birth, current address, current e-mail address and day time telephone number.
2. Specific treatment dates: Please list specific dates; past year or past two years. If you do not remember the specific dates please indicate at least a time frame such as last month, last six months, etc.
3. What records do you want? Mark the documents that you are requesting. Test results when marked individually are generally for specific dates of service as indicated in the next section.
4. I request my records to be sent to: Check the appropriate box. If records are being sent to someone other than the patient, then specify whom the records should be released to.
5. How would you like your records delivered? Records will be released electronically rather than on paper unless otherwise specified. Electronic format would include releasing directly to your patient portal, secure e-mail, or CD. CDs or paper records will be mailed to the address provided. Please call Urology Experts at 239-226-2727 in advance of picking up records. When picking up records in person, a photo ID will be required as well as a copy of any legal papers (power of attorney, executor of estate, proof of custody, etc.).
6. If records are going to be picked up by someone other than the patient, the name of the individual picking up the records should be listed: Please complete the name, phone number, address of the individual who will be picking up your medical records. A driver's license or photo ID will be required to be shown at the time of picking up the medical records.
7. Patient/Personal Representative Signature: This form should be signed by the patient. If the patient is unable to sign and the request is being made by an authorized personal representative of the patient (parent of a minor, person named on Power of Attorney, executor of estate, etc.), the Personal Representative should sign and date the form. Please provide printed name and relationship to the patient. Supporting legal documentation must accompany this authorization form when signed by a personal representative.
8. Witness Signature: A witness must sign and date the form in the event that the patient can only make an X or is unable to sign.

Please email or call Urology Experts at 239-226-2727 if you have any further questions.

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