LAKE REGIONAL® HEALTH SYSTEM

Electronic Record Delivery Request

Complete this form, along with a HIPAA Authorization, to receive your medical records as electronic PDF files rather than as printed copies.

Requester Name			
	First	Last	
Street Address			
	Street	Suite / Apt #	
	City	State	Zip

Email Address for record delivery

Medical Records Requested			
Patient Name			
	First	MI	Last
Date of Birth			
Date of Service			
	From	To	

Please provide me with the medical records described above through the HealthPort eDelivery online service. I understand and agree that:

- I must provide a valid email address, either my own or that of my designated recipient.
- My records will be provided as Adobe PDF files on HealthPort's **eDelivery** website.
- I will receive an email from **HealthPort.com** containing instructions for accessing my records.
- There may be a fee for collecting my records. If so, an invoice will be included with the records.

Signature _____ Date**:** _____

HealthPort®

Acknowledgement of Medical Record Request Processing Fee

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows a fee (whether regulatory or statutory) to be associated with medical record request processing, excluding those that are needed for continuing care purposes.

Lake Regional Health System has partnered with HealthPort Technologies, LLC to process and fulfill your request for a copy of your medical record. The regulated fee in the State of Missouri is detailed below.

Detail of State Rates: **$0.54 PER PAGE**

By signing below, I acknowledge that I am aware of the fee that will be billed to me for requesting a copy of my medical record. I agree to pay this fee when services are rendered and I receive an invoice from HealthPort Technologies.

Name: _____ Phone #:_____

Address:

_____

Street City State Zip

Patient Signature: _____Date:_____
(or authorized representative)

Email address for electronic delivery request for medical record:

_____

The fee should be remitted to HealthPort Technologies as directed on the HealthPort invoice you receive.

Please note that there is no fee for medical record requests sent directly to a physician or healthcare facility for continuing care purposes.

HealthPort Technologies, Inc. Release of Information Processing Center
120 Bluegrass Valley Parkway Alpharetta, GA 30005
Customer Service: 800-367-1500

LAKE REGIONAL HEALTH SYSTEM
54 HOSPITAL DRIVE, OSAGE BEACH, MO 65065

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Rvw. 11/12
Rev. 1/14

Fax: (573) 348-8223 (HIM) Phone: (573) 348-8729 (HIM) Other Fax: _____ Other Phone: _____

We are required by law to obtain your authorization to use or disclose your health information in certain circumstances.

You may refuse to sign this Authorization. You will not be refused health care treatment, payment for health care services, enrollment in a health plan or eligibility for health care benefits if you do not sign this Authorization.

Once this information is disclosed to the person or persons identified below, your information may be subject to redisclosure by that person or persons.

You may revoke this Authorization at any time by sending a written notification to the attention of the Privacy Officer at the address listed at the top of this form. Such revocation will not apply to information that we have already used or disclosed in reliance on this Authorization. Unless you revoke this Authorization in writing, this Authorization will expire:

☐ _____ days from the date this Authorization Form is signed; or
☐ Upon the expiration of the event for which this Authorization Form is requested.

You have the right to inspect and copy the information that may be used or disclosed pursuant to this Authorization. We may charge you a reasonable fee for copying and mailing this information. A copy of this Authorization will be provided to you after you sign it.

HEALTH INFORMATION TO BE USED OR DISCLOSED:

Patient Name: _____ Date of Birth: _____ SSN: _____

Complete Address & Telephone Number _____

_____

Date(s) of Treatment Requested _____

I request only the following information to be released/obtained:

☐ Designated Record Set ☐ Operative Report ☐ Mammograms ☐ EKG
☐ Emergency Report ☐ Pathology Report ☐ Cardiac Cath Lab Cine Film
☐ Discharge Summary ☐ Radiology Reports ☐ Cardiac Cath Lab Reports
☐ History & Physical ☐ Radiology CDs ☐ Photographs, videotape, Digital, or other images
☐ Laboratory (specify):_____
☐ Other (specify): _____
☐ Itemized Billing Statement

_____ EXCEPT those relating to care and treatment for mental health conditions; drug or alcohol abuse; HIV testing, infection status, or care and treatment for AIDS.
_____ INCLUDING the following: _____ Relating to care and treatment for mental health conditions
_____ Relating to care and treatment for drug or alcohol abuse
_____ Relating to HIV testing, infection status, or care and treatment for AIDS

_____ Patient will pick up _____ Mail _____ Fax to Doctor Only _____ Fax Number

PURPOSE OF THE USE OR DISCLOSURE OF HEALTH INFORMATION:

The information described above is being used / disclosed to _____

Address: _____ Phone: _____

for the following purpose: _____

Do you want PHI electronically? ☐ Yes ☐ No If yes, please provide valid email address_____
You will be directed to a secure website and given a generic password.

SIGNATURE OF PATIENT

I, _____ have read and understand the above information and authorize:

☐ LAKE REGIONAL HEALTH SYSTEM ☐ LAKE REGIONAL IMAGING PARTNERS, LLC ☐ Other_____
to use or disclose the information identified above to the persons and for the purpose described above.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to patient if signed by other than the patient Signature of Witness

(FF-00309)

You have requested an electronic copy of your medical records. HealthPort will, under agreement with Lake Regional Health System, facilitate the release of your records based on your authorized request.

You will receive an email from HealthPort, at the email address you have provided, that will include detailed instructions on how to access your electronic records via a secure web portal. Once you have received the email notification from HealthPort, the medical record will be available via the web portal for 30 days. If the record is not accessed during that timeframe, it will be deleted from the portal. If you need the record after that time, you must resubmit your request to the health care facility.

To access the record electronically your computer must meet or exceed these requirements:

- Windows or Mac platform
- Pentium 3 or Mac G3 or higher
- At least 128 MB of RAM
- Internet Explorer 6.0 or 7.0 with 128-bit encryption pack or Netscape 4.77
- At least 56K modem; however, DSL or T1 line is recommended
- Adobe Reader (latest version available free from www.adobe.com)
- 200 dpi (or higher) printer (for printing records)

Payment regulations vary from state to state, therefore, depending on the location of the medical facility that you requested the records from, there may be a charge associated with this service. Missouri state rates for patient records are $0.54 per page, you will receive an invoice from HealthPort along with the medical record.

If you have any questions or to check on the status of the medical record, please call us directly at (800) 367-1500, #4.

Kind regards,
HealthPort