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 304-487-7553 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.
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

___ Laboratory Reports

___ Emergency Room Report

___ Surgical Report

___ Medications

___ Billing records

___ Other information or instructions________________________________________________

___ Mental health

___ Discharge Summary

___ Progress Notes

___ Consultations

___ Immunizations

___ Pathology

___ HIV/AIDS testing

___ Radiology Reports

___ Radiology images

___ Photographs, video, digital/other images

___ Drug/Alcohol Records

___ Pathology

___ Cardiopulmonary

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

___ Legal

___ Payment

___ Insurance application

___ Treatment/continued care

___ Other __________________________

Please specify

2.30H - Form 1A
Revised 1/2/2012; 4-29-2014
11-18-14; 2-2016
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

2.30H – Form 1A
Revised: 1/2012; 4-29-2014
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