



Council Grove, KS 66846  
600 N Washington  
(620) 767-6811  
Fax (620) 767-5611

**Request by Patient for Access to Protected Health Information**

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Patient Date of Birth or SS#

You have a right to inspect, or to obtain a copy of, your protected health information maintained in the designated record set of the Morris County Hospital. Your request must be made in writing using this form. The form must be completed prior to us providing you the requested information.

We will make every reasonable effort to provide the protected health information requested in a legible, hard copy format.

We may provide you with a summary of the protected health information requested, in lieu of providing access to the protected health information, or may provide an explanation of the protected health information to which access has been provided, if you agree, in advance, to the summary and explanation and if you agree, in advance, to the fees imposed for such summary.

The fee for copying your protected health information or providing a summary to you is \_\_\_\_\_.

I hereby request the Morris County Hospital to copy the following records and mail them to me at:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Records to be copied (Specific dates and types of records): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I hereby agree to pay the Morris County Hospital for the cost of copying the records.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

**OR**

\_\_\_\_\_  
*Signature of Personal Representative of Patient*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Description of Representatives Authority to Act for Patient*