Patient's Request to Access Protected Health Information ("PHI")

Patient's Name:____Patient's Date of Birth: ______________________

Patient's Address:____

Patient's Phone Number: ____

I request a copy of the following PHI: *(please check the boxes below)*

☐ Billing Statements	☐ Health Information	☐ Other (specify)

Date(s) of Service of PHI Requested: From Date:________________________To Date: _______________________

(if dates are not specified, records will be provided for all dates of service)

IMPORTANT: If my record contains information regarding drug/alcohol abuse, mental health treatment, HIV/AIDS testing or treatment, genetic information, communicable diseases or other sensitive information I request that such information be included with my records: ☐ **Yes *(include with my records)*** ☐ **No *(do not include with records)***

I request that PHI specified above be provided:

☐ To me

☐ To the following person/entity: ____

(Specify name and address of person/entity to whom you would like your PHI to be sent)

I request that PHI be provided in the following format (if readily reproducible in this format):

☐ Paper Copy

☐ Electronic Copy via *(check below)*

☐ PDF Attachment to E-Mail ☐ CD ☐ Web Fax

☐ Other:______________________________

I request that access to PHI be provided by the following method:

☐ Personal pick-up

☐ Inspection: *Requested Appointment Date/Time*: ____

(You will receive a call at above phone number to confirm this requested appointment)

☐ Mailed to the following address: ____

☐ Emailed by **Unsecure Mail** to the following e-mail address: ____

☐ Faxed to the following fax number: ____

☐ Other: *(specify)* ____

ACKNOWLEDGMENT: I understand that the CD is not secure and that I am responsible for protecting information on the CD. I also understand that unsecure/unencrypted e-mail is not secure and while in transit it can be

intercepted and seen by others. **By requesting to receive my PHI electronically on a CD or by unsecure e-mail I acknowledge that I understand and accept these risks.**

I understand that I may be charged a reasonable fee for the costs of labor for copying, postage, supplies as permitted by HIPAA Privacy Rule and state law.

Printed Name: ____

Signature: ____

Date: ____

Access Requested By: *(Check One)*

☐ Patient ☐ Parent (for minors) ☐ Personal Representative

If this request is signed by the patient's personal representative:
Please specify your authority to act on behalf of the patient and attach supporting documentation:

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INTERNAL USE ONLY

Verification Via:

Photo ID: ☐ Yes ☐ No

Matching Signature: ☐ Yes ☐ No

Other: *(specify)* ____

Personal representative documentation provided and checked: ☐ Yes ☐ No

Request: ☐ Approved ☐ Denied (reason:____)

Processed by:____Date: _______________