PATIENT ACCESS REQUEST FORM

You (or your authorized representative) have the right to inspect or obtain a copy of your Protected Health Information (PHI) that we maintain in a designated record set. If we maintain your PHI in electronic format, then you also have the right to obtain a copy of that information electronically.

Generally, we will provide you (or your authorized representative) access to your PHI within thirty (30) days of your request. In limited circumstances, we may deny you access to your PHI, and you may appeal certain types of denials. We may also charge you a reasonable cost-based fee for providing you access to your PHI, subject to the limits of applicable State law.

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Date of Birth: _____

Date of Request: _____

I would like to:

☐access my PHI maintained by

☐obtain a **PAPER** copy of my PHI.

☐obtain an **ELECTRONIC** copy (CD) of my PHI.

The specific information I would like to access or receive a copy of is as follows:

☐**Entire Record**		
☐Chart Notes	☐Medication List	☐Billing
Other (Please Specify)_____		

I want to access my PHI that covers the following time period:

_____

Please pick one method for delivery of your records:

☐ Contact me at _____ when the information is ready to be picked up.

☐ Send the copies of my record(s) to me at the address listed above.

☐ Send the copies of my record to me at the following address:

_____

_____

Signature of patient or representative _____ Date _____

Relationship to patient (if representative): _____

When you have completed this form, please return it to our office.