REQUEST TO ACCESS PROTECTED HEALTH INFORMATION (PHI)

Please print all requested information to prevent delays in our response & provide completed form to your facility.

Patient Name: _____
Last **First** **MI** **Maiden or Other Name**

Address:_____City:_____ST:_____ Zip:_____

Date of Birth: _____-_____-_____ Phone #:_____
M D Y

Type of access requested: ❑ Actual Copy ❑ Summary or explanation ❑ View on Site

I request access to: (Please check only one box):

- ☐ **All of my protected health information in my medical records, including mental health, HIV, health status or substance abuse records.**
- ☐ **Protected health information for the dates of: (_____) to (_____).**
- ☐ **Protected health information about the following condition or injury:_____**
- ☐ **Other (please describe):_____**

Please send records ❑ To me OR ❑ To:

_____
(Name and Address, if mailing)

Method: ❑ Paper Copy ❑ call at number above to pick up or ❑ mail by USPS to address above
* ❑ Email_____or ❑ other electronic method _____
***For security of your records, all emails are sent encrypted.**

Unencrypted email disclaimer:

❑ **I understand that records sent through unencrypted email pose a security risk but it is my requested method of receipt._____(Please initial)**

_____ _____ _____ _____
SIGNATURE OF INDIVIDUAL **DATE** **SIGNATURE OF PERSONAL REPRESENTATIVE** **DATE**

_____
RELATIONSHIP TO INDIVIDUAL

FOR INTERNAL USE ONLY

Complete the sections below and retain this request with patient medical records.

Date Request Received:_____ ❑ mail ❑ in person ❑ email ❑ fax

Notice of Decision is: ❑ Approved and provided per request ❑ Denied for reason indicated below:

❑ Information requested is not a part of patient's designated record set.
❑ Information requested is not available to the patient for access as required by federal or state law.
❑ A physician has determined that access to information requested may endanger the life or physical safety of the individual or another person.
❑ Other: _____

_____ _____ _____ _____
Physician who reviewed if applicable **Title** **Phone** **Date completed**

_____ _____ _____ _____
Staff member who processed request **Title** **Phone** **Date completed**