

Request for Access to Protected Health Information

(Practice Information)	
Patient Name:Patient DOB:	
Contact Information:	
to access your protected health inf obtaining a copy. There are certair	or designated personal representative have the right formation (PHI) for the purposes of inspection and/or a conditions under which we are permitted to deny by conditions of denial will be explained to you.
that, due to privacy and risk m may only be inspected in the p	PHI is provided on a scheduled basis. Please note anagement guidelines, original documents of PHI presence of one of our staff members and original I from the facility. Our receptionist can provide at the time of your request.
we may charge a reasonable,	ve copies of your protected health information, cost-based fee. If a copy fee applies, the to you at the time of your request.
☐ Release to Third Party – If you party, please complete the follows:	wish to release a copy of your records to a third owing:
Who will be authorized to receive your PHI):	eive information (list the individual/entity who is to
Individual/Entity Name:	
Address:	
Email*:	

*Secure Communication – Note that regular email and some fax transmission methods are not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate email or fax as your preferred method of disclosure if this is of concern to you.

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:



□ Entire patient record; or, send only the following:
If applicable, please specify the format in which you would like copies of PHI provided to you, or your designated recipient. We will accommodate your request, if possible.
□ paper copy □ electronic copy – preferred format:
This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information release prior to notification or cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations.
Patient Name
Patient or Guardian Signature Signature Date

