REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

PATIENT OR LEGAL REPRESENTATIVE MUST COMPLETE ITEMS 1 - 13

1. Today's Date

2. Patient's Name

3. Patient's Date of Birth

4. Patient's Medical Record Number (if known)

5. Patient's Social Security Number

6. Describe the information you are requesting access to: _____

_____

7. Date(s) of the information you are requesting to restrict: _____

8. Are you requesting:
   - ☐ to inspect the protected health information (PHI)
   - ☐ a copy of the PHI (cost based fee may be involved)

9. What is the reason for this request? _____

_____

10. Signature of Patient or Legal Representative

11. Date

12. Printed Name of Patient's Legal Representative

13. Relationship to Patient

DO NOT WRITE BELOW THIS LINE

HEALTHCARE ORGANIZATION MUST COMPLETE ALL ITEMS BELOW

Access to the requested PHI has been:
- ☐ Granted
- ☐ Denied

If denied, indicate reason for denial: _____

_____

Signature of Authorized Individual

Date

Printed Name and Title of Authorized Individual