



The purpose of this form is to request access to or a copy of protected health information. Date of Request: _____

Information on Person Requesting Access / Copy

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Medical Record/Set: _____

Action Requested

Access to Inspect Protected Health Information

Copy of Protected Health Information – Indicate Number of Copies _____.

Format Requested (Circle Desired Format): Summary Detail

Fees for Request

The following fee will be imposed to receive a copy of your protected health information:

\$ _____

Acknowledgment of Request

I hereby acknowledge the above request and understand that I will be responsible for the payment of the above fee (if any) in connection with this request.

Signature of Patient or Legal Patient Representative _____ *Date* _____

[Note: All requests will be honored within 30 days, unless an extension is required in which case the above request will not take longer than 60 days to fulfill.]

***** [Do Not Write in

Section Below – For Healthcare Provider Use Only]

Assigned To: _____ Date Delivered to Patient: _____

Extension Requested: Patient Notified: Request Denied:

Date Notified: _____ Reason: _____