Request to Inspect or Copy Protected Health Information

Patient:

____ ________________

Patient name/Previous name(s) Date of birth

____ ________________

Street Address, City, State, Zip Code Phone number

Release my protected health information to: ☐ Myself ☐ Individual Noted Below

Individual name: ____

Business Office (if applicable): ______________________________________

Street Address: ____

City, State, Zip Code: ____

Phone #: ____________________ Fax #: ____________________

Information to be Disclosed

Date(s) of Service: ____

__ Office visit clinic notes __ Procedure reports __ EKG Reports

__ Telemedicine visit notes __ Laboratory reports __ Radiology Reports

__ Telephone notes __ Consultations __ Pharmacy Notes

__ All Medical Records __ Immunizations

__ Other: ____

We may be prohibited from making certain information available to you or your representative, including:
-Psychotherapy notes
-Information related to medical research in which you have agreed to participate
-Information related to legal proceedings
-Information obtained under a promise of confidentiality
-Information that federal or state laws prevent us from disclosing
-Information for which the disclosure may result in harm or injury to your or to another person

This information is to be: ☐ Mailed ☐ Picked up ☐ Faxed ☐ Inspected ☐ Other:

Please choose format: ☐ Paper copy ☐ Electronic Media

Your rights with respect to this request:
Within the limitations of law, we will make every effort to accommodate your request. We will complete our review of your request and as requested either provide a copy or arrange for you to inspect your records within 15 business days of your request, provide you with a written explanation of any restriction on the information that we can provide you, or provide you with a written explanation of our denial of your request.

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Printed Name of Patient or Legal Representative and Relationship

____ ________________

Signature of Patient or Legal Representative Date