Palm Harbor Dental Care

Patient Request for Access Form

Patient Name:____
Patient Address:____
Date of Birth:____________________Social Security No.:______________________________

I elect to exercise my rights under federal and state laws to obtain copies of my protected health information. I understand that my request will be reviewed and that in some circumstances I may not have the right to access all information. I understand that my request will be acted upon within the time permitted by law. I further understand that there may be a fee for copies and postage.

Information I am requesting: _____ Treatment Plan _____ Duplicate X-Ray

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I would like to: _____ Pick up copies at the office _____ Have copies mailed to my home
_____ Have copies e-mailed directly to my healthcare provider (no charge)

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I understand that Dr. Chadha and her affiliates are permitted, under certain circumstances, to deny me access to my records. This includes photocopy notes; information related to civil, criminal, or administrative actions or proceedings; or information obtained from anyone other than a healthcare provider under a promise of confidentiality. I understand that I have the right to review Dr. Chadha’s Notice of Privacy Practices, should I request to do so.

Date: _________________________ Patients Signature:__________________________________