Access to Protected Health Information (PHI) Request Form

You have the right to have access to your personal health information located in the Designated Record Set that our practice has. The Practice may deny you access to your personal health information if:

- Your personal health information contains psychotherapy notes or is gathered to prepare for and use in a civil, criminal or administrative proceeding; or
- A licensed healthcare professional has determined that access to your personal health information is likely to endanger your safety or the safety of another person.
- You may inspect your personal health information at the Practice's office, or you may have a copy of your personal health information sent to you.
- The request must be in writing.
- Hard copies shall be charged at $1.00 per page for the first 25 pages, and .25 cents for each additional page. For reproducing x-rays or any other specific types of reports, they will be charged at the actual cost of the reproduction including supplies and labor associated with the request.
- If the patient prefers medical records to be on a USB flash drive, it must be in a new unopened package, and the cost for duplication will be $10.00.
- You may have a written summary or your personal health information sent to you. The average cost of a summary or an explanation is $25.00.

Patient name: _____ **DOB:** _____

Address: _____

Phone: _____

The specific information I would like to access or receive a copy of is as follows:

____ Entire Record ____ Consultation Notes ____ Progress Notes

____ Operative Reports ____ Radiology Reports ____ Laboratory Reports

____ Pathology Reports ____ Billing Statements ____ Other

Explain Other: _____

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I want access to my PHI that covers the following time period:

From date:_____ To date: _____

____ I want to inspect my personal health information in the Practice's Office.

____ I want to pick up a copy of my personal health information at the Practice's Office, I understand I will be charged per page or the cost of duplication.

____ I want the Practice to send me a copy of my personal health information; I understand I will be charged per page or the cost of duplication.

____ I want the Practice to send me a written summary of my personal health information.

This form must be signed by EITHER the patient OR by the personal representative. The recipient's parent may sign for the recipient if the recipient is a minor.

Signature of Patient: _____ Date: _____

If this form is signed by the personal representative, please include a copy of the document naming the personal representative, for example, a Power of Attorney, Personal Representative Designation form, or order appointing a guardian or executor.

Signature of Representative: _____ Date: _____

Relationship to Patient:_____

FOR INTERNAL USE:

____ Patient reviewed records in the practice
____ Patient picked up records from the practice
____ Mailed records to patient
____ Mailed written summary of personal health information

Office Staff Signature: _____ Date: _____