**[Insert Facility Name]**

**Patient Request to Inspect and/or Copy Protected Health Information**

|  |
| --- |
| Patient Name: |
| Account Number: | Date of Birth: |

I hereby request that [Insert Facility name] grant me [or the following designated individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_] access to

*Check One:* \_\_\_\_\_\_\_\_\_\_ Inspect \_\_\_\_\_\_\_\_\_\_ Copy \_\_\_\_\_\_\_\_\_ Inspect & Copy

my personal health information maintained by [Insert Facility name]

If a copy of my personal health information is being requested, it should be (*check one*):

 picked-up by myself or the designated individual stated above.

 mailed to the following address:

*With respect to the above two choices, please specify if you would prefer a paper or an electronic copy of the information: paper copy electronic copy (e.g., CD or USB)*

 e-mailed to the following e-mail address:

 faxed to the following fax number:

Provide a specific description of the personal health information you are seeking to access (*include dates of service, type of service, etc.*):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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By submitting this request I understand:

1. That [Insert Facility name] may deny my request to access my health information, with or without review, depending on the type of information I am seeking and whether [Insert Facility name] actually maintains this information.

2. If I agree, I may be provided with a summary or explanation of the health information requested, in lieu of being provided access to the information. By initialing below, I am indicating that I am willing to accept a summary or explanation of the health information I have requested and to pay all fees associated with this request.

*Your Initials*: \_\_\_\_\_\_\_\_\_\_\_\_ Please send a summary or explanation of my health information. I agree to pay all fees associated with this request.

3. That[Insert Facility name] may impose a reasonable fee for accessing my health information in accordance with applicable law.

**BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND THE TERMS AND CONDITIONS OF REQUESTING MY HEALTH INFORMATION.**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Patient's Representative Date

Printed Name of Patient's Representative (*if applicable*)

Representative's Relationship to Patient (*if applicable*)

Representative's Relationship to Patient (*if applicable*)