



## Patient Request for Access Form

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name & Title of Person Requesting: \_\_\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient Social Security No: \_\_\_\_\_ DOB \_\_\_\_\_

Date(s) of Service: \_\_\_\_\_

**Patient Rights:** As a patient, you have the right to access, copy or inspect your protected health information, or PHI, in accordance with federal law. You may also have the right to request an amendment to your PHI, or request that we restrict the use and disclosure of it. These rights are further described in our Notice of Privacy Practices and I other policies, which you may have upon request. Only patients or guardians may request protected health information. If the patient is deceased, a certificate of death must be produced before information will be released.

**To better allow us to process your request, please indicate the type of request you are making on this form: (Check all that apply)**

\_\_\_\_\_ Access to simply review **my health information**.

\_\_\_\_\_ Access to obtain **copies of my health information**.

\* I understand that this copy a non official copy and can not be used in a court of law.

\_\_\_\_\_ Access to review and potentially **request amendment** of my health information.

\_\_\_\_\_ Access to review and potentially **request an accounting** of my PHI has been used and disclosed to others.

\_\_\_\_\_ Access to review and potentially request **restrictions on the use and disclosure** of my health information.

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_

Identification Information \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_