

PATIENT ACCESS TO PHI

(Protected Health Information – To Include All Contents of the Designated Recorded Set)

This form must be completed when a patient is granted access to or we send copies of his/her PHI to the patient or a 3rd party at the patient's request.

Patient Name: (First, Middle, Last)					
Address:		City		State	
Zip		Date of Birth:			
Phone #:		Email Address:			

<input type="checkbox"/>	This record request is for records to be sent to the patient.
<input type="checkbox"/>	This records request is to direct medical records to:

Please check all that apply:

<input type="checkbox"/>	I am requesting all of my medical records.						
<input type="checkbox"/>	I am requesting the following medical records.						
<input type="checkbox"/>	Visit Summary	<input type="checkbox"/>	Lab Reports	<input type="checkbox"/>	Medications List	<input type="checkbox"/>	Radiology Reports
<input type="checkbox"/>	History & Physical	<input type="checkbox"/>	Other: List				

I am requesting the records from:	Click here to enter a date.	to	Click here to enter a date.
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Format of Records to be delivered: Choose an item. Other: _____

Records will be Mailed Pick-Up Emailed* Faxed

Other:	
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Signed: Patient		Date:	
Signed: Patient Representative		Date:	

ID Provided:	
Request Taken By Phone (Verification)	

*-Patient must be warned that email is an insecure delivery method and records could be intercepted.

<u>Practice Use Only</u>			
Fee Charged:		Date Records Delivered:	