



## 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 3<sup>rd</sup> 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:	<a href="#">Click here to enter a date.</a>	to	<a href="#">Click here to enter a date.</a>
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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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<b>Signed: Patient</b>		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.

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