



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.

Form with fields for Patient Name, Address, City, State, Zip, Date of Birth, Phone #, and Email Address.

Form with checkboxes for record request types and a text field for direct medical records.

Please check all that apply:

Form with checkboxes for 'I am requesting all of my medical records' and 'I am requesting the following medical records' with sub-options like Visit Summary, Lab Reports, etc.

Form with text: 'I am requesting the records from: [Click here to enter a date.] to [Click here to enter a date.]'

Format of Records to be delivered: Choose an item. Other: _____

Records will be [] Mailed [] Pick-Up [] Emailed* [] Faxed

Form with text: 'Other: _____'

Table with 2 columns: Signature (Signed: Patient, Signed: Patient Representative) and Date.

Form with fields for ID Provided and Request Taken By Phone (Verification).

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

Practice Use Only

Form with fields for Fee Charged and Date Records Delivered.