PATIENT REQUEST FOR ACCESS TO HEALTH INFORMATION

Patient Name: ____

Address: ____

City: _____________________ State: ______ Zip Code: ____________

Phone Number: ____

Requesting Party, if other than patient: ___________________________

Date of Incident: ____________________

Location of Incident: ____

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 in other District policies which you may have upon request.

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 review my health information.

_____ Access to obtain copies of my health information.

_____ Access to review and request amendment of my health information.

_____ Access to review and request an accounting of how my PHI has been used and disclosed to others.

_____ Access to review and request restrictions on the use and disclosure of my health information.

Signature _________________________ *Request Date* _______________

Relationship to Patient:__________________________

Parent, Guardian

Please indicate how you would like to receive the records: ____Mail ___Pick up at Station