Patient Request for Access to Health Information

PATIENT INFORMATION

Name: _____Today's Date & Time: _____

Telephone #: _____Fax #: _____

Address: _____

City: _____State: _____Zip: _____

Email: _____

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:

_____ 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 _____

Relationship to Patient: _____
(Self, *Parent or Guardian)*

Copy of Identification is required to release information.

How do you wish to receive this public record?

☐ Email ☐ Fax ☐ Mail ☐ Pick up at station

DEPARTMENT USE ONLY

☐ Request granted ☐ Record withheld ☐ Record partially withheld ☐ No record found

_____

Records Officer: _____ Date & Time: _____