



REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION
PATIENT OR LEGAL REPRESENTATIVE MUST COMPLETE ITEMS 1 - 12

1. Today's Date _____

2. Patient's Name _____

3. Patient's Date of Birth _____

4. Patient's Medical Record Number (if known) _____

5. Patient's Social Security Number _____

6. Describe the information you are requesting access to: _____

7. Date(s) of the information you are requesting to restrict: _____

8. Are you requesting: to inspect the protected health information (PHI)
 a copy of the PHI (cost based fee may be involved)

8. What is the reason for this request? _____

9. Signature of Patient or Legal Representative _____

10. Date _____

11. Printed Name of Patient's Legal Representative _____

12. Relationship to Patient _____

DO NOT WRITE BELOW THIS LINE

HEALTHCARE ORGANIZATION MUST COMPLETE ALL ITEMS BELOW

Access to the requested PHI has been: Granted
 Denied

If denied, indicate reason for denial: _____

Signature of Authorized Individual _____

Date _____

Printed Name of Authorized Individual _____