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REQUEST TO ACCESS AND/OR COPY HEALTH INFORMATION

Please complete the following:

1. Name of Requestor (Print): _____
2. Patient's Name (If Different): _____
3. Patient's Date of Birth: _____
4. Address: _____
5. Phone: _____
6. If you are not the patient, your relationship to the patient: _____
7. Do you wish to ❒ access (e.g. review) the health information, ❒ copy or receive an electronic copy of the health information, or ❒ both.
8. Describe the information you want to access (e.g., payment information, test results, physician notes):
   _____
   _____
9. Identify the date(s) of information you want access to: _____

Do you wish to send your requested health information to a third party? ❒ YES ❒ NO
If YES, where do you wish to send your requested health information?

Third Party's Name: _____

Address: _____

City, State, Zip Code: _____

There is no charge to access your health information. If you would like a copy of the information, we will charge a reasonable fee for the copying, postage, and to prepare a summary (if you request a summary). We will inform you by ❒ phone ❒ letter (pick one) of the cost of your copy before we make the copy and verify that you agree to pay for the copy. We will require you to pay for your copy before you receive it. We will notify you in writing within thirty (30) days of your request if and when your health information will be available for access, where you will need to come to access your health information to read and review it, or where to come to pay for and pick up your copy. We will notify you within thirty (30) days if we need one additional period of thirty (30) days to respond to your request. In specific circumstances, we may deny access to your health information, or to a portion of your health information. If we deny access we will return this form to you with our written reasons for our denial and explain your right to review the denial, if applicable. The Clinic reserves the right to supervise your access.

Signature of Patient (or Patient's Representative):	Date:
Print Name of Patient (or Patient's Representative):	
If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:	
❒ Power of Attorney ❒Legal Guardian ❒ Surrogate Decision-Maker ❒ Executor or Personal Representative ❒ Parent ❒ Other: _____	