Patient Access Request for Protected Health Information

NOTE: This form is only for a patient/legal representative to request medical records be sent to the patient. A HIPAA compliant Authorization to Release Medical Information must be submitted for release of patient's information to anyone other than the patient.

1. Patient Information (Please print)

Patient's Full Name: _____ Birthdate: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Phone: _____ Email: _____

Date of Incident/Service: _____

2. **What records do you want?**

_____

_____

3. How would you like your records delivered?

[ ] Mail the paper information to my home address listed above (Fees apply)

[ ] I will pick up the records in person (Government Issued Photo ID will be required) (Fees apply)

[ ] ***Unsecured Email: _____

[ ] ***Unsecured Fax: _____

*** Warning: Records will be sent through unencrypted fax/email that is not secure and there is a risk that the records could be seen by a third party during electronic transmission, while in electronic storage, and/or upon completed delivery. The District is not responsible for unauthorized access of the Protected Health Information resulting from the faxed or emailed transmission, or for safeguarding the Protected Health Information upon delivery.**

4. _____

Printed Name of Legal Representative if Patient is Not Capable of Signing

If this form is not signed by patient, identify relationship to patient. If legal representative or other, provide documentation establishing authority such as Power of Attorney.

5. _____

Signature of Patient or Legal Representative **Date**