[NAME OF PRACTICE]

REQUEST FOR ACCESS TO HEALTH INFORMATION

You have a right to request access to review and to receive copies of your protected health information. Please see [Name of Practice] ("Covered Entity") Notice of Privacy Practices or contact Covered Entity's Privacy Official at [Practice Phone Number] for information.

Please submit this form to: Privacy Official
[Name of Practice]
[Address of Practice]

Name _____

Address _____

Daytime telephone number _____

Please select one:

_____ I am a patient of Covered Entity.

_____ I am the personal representative of a patient of Covered Entity (*please attach proof of personal representative status*).

I would like access to the following information:

_____
_____
_____

Please provide my health information dated between _____ and _____.

I prefer to review the information in the following manner (please select one):

_____ Mailed copy

_____ Electronic copy

_____ View at the Company's business offices

_____ Other (describe on a separate sheet)

Electronic Format Requested: _____

_____ I agree to accept a summary of the above requested information and to pay a reasonable charge for the costs incurred by Covered Entity in preparing such summary.

Please Read Carefully and Sign

I understand that Covered Entity will provide the requested access if required to do so under applicable law. I also understand that I will be charged for copying and postage in accordance with Covered Entity's Notice of Privacy Practices.

_____ _____
Signature Date

Please note: Applicable law requires us to respond to you within 30 days after receiving your request. We are entitled, in certain circumstances, to an additional 30 days in which to respond. We will send you written notice if we determine we will need the additional 30 days.