PATIENT REQUEST TO INSPECT PROTECTED HEALTH INFORMATION (PHI)

Patient Name:

Patient Address: MM / DD / YY

Medical Record #: Date Of Birth:

Other Identifier (Social Security Number):

Please consider this a request for me to exercise my rights under federal and state laws to inspect and review my protected health information. I understand that my request will be reviewed and that in some circumstances I may not have the right to access all information. I understand that my request will be acted upon within 30 days if my records are on site (or 60 days if off site). I further understand that I will be contacted by the practice when my records are available for review.

Date of Request	Describe the information you want to inspect or review	Provide the dates that you want to review

Tell us how you would like to review this information: ☐ I would like photocopies mailed to me ☐ I would like to arrange to review the records in your office ☐ I would like an explanation of the records when I review them in your office

I understand that the physician (or provider) to whom I am making this request, is permitted, under certain circumstances, to deny me access to my records. This includes photocopy notes; information related to civil, criminal, or administrative actions or proceedings; or information obtained from someone other than a healthcare provider under a promise of confidentiality. I understand that there may be a fee for copies and postage.

Date: Patient Signature:

FOR OFFICE USE ONLY

Date	Action	Initials	Notes
	This request reviewed		
	This request granted		
	Patient reviewed records in office		
	Copies sent to patient		
	This request denied		Reason for denial:
	Denial (in writing) sent to patient		(attach copy)