



ACCESS TO PROTECTED HEALTH INFORMATION REQUEST FORM

Client Name: _____
Last First Middle

Date of Birth: _____ *If the client is 18 years or older, they must submit their own request.*

Primary Phone Number: _____ **Alternate Phone Number:** _____

- 1) I hereby request that Child & Family Center (C&FC) provide me with
- Access to the "Requested Information"
 - A copy of the "Requested Information" checked below:

- 2) Requested Information:
- My medical records
 - My billing records
 - Any other personally identifiable information used by C&FC to make medical decisions about me

Additional Details about Requested Information: _____

- 3) Please select the type of copies:
- I would prefer to receive the Requested Information in the form of a summary prepared by C&FC.
 - I am only interested in accessing or obtaining a copy of Requested Information relating to the time period _____ through _____.
 - I am interested in accessing or obtaining a copy of all Requested Information maintained by C&FC.

- 4) Please provide the Requested Information in:
- Paper form
 - Electronic media
 - Email

- 5) I would prefer to have the Requested Information:
- Available for pick-up or view at a mutually agreeable time and place
 - Faxed to the fax number below
 - Mailed to me at the address below
 - Mailed to another person or entity at the address below
 - Email to the email address below
- The Custodian of Records will send email communications through secure messaging.***

Name of Recipient: _____

Mailing Address: _____

Email: _____

Fax Number: _____

