REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

UNIVERSITY MEDICAL SERVICES OF CEDARVILLE UNIVERSITY

Patient Name:_____

Address: _____

Date of Birth: _____ Date of Request:_____

As allowed by the Privacy Regulations, I wish to access the following information contained in my protected health records: (*Please be specific*)

_____

_____

_____

I would like the following access:

☐ **Review**. I would like to make an appointment to review this information.

☐ **Copies**. I would like copies of the above-listed information.

☐ **Format**. I would like to receive the above-listed information in the following format, if available, at this office: _____

Charges
I understand that I may be charged reasonable clerical costs and that you may charge a copy or other fee associated with this request. I agree to pay these costs prior to receipt of the requested information.

Response
I understand that you will either grant or deny this request within the prescribed time period and the response will be in writing with an explanation as required by the Privacy Regulations.

_____ _____
Signature Date

_____ _____
Authorized Signature of Facility Date

©H.J. Ross Company, Inc. 2002, 2003 HIPAA Interactive-All Rights Reserved