PATIENT REQUEST FOR ACCESS FORM

Patient Name: ______________________ Account/Call #: ___________ Date: __________

Address: ____

City: __________________________ State: ___________ Zip Code: __________________

Phone Number: ______________Date of Birth: ____________ Last Date of Service: _________

Patient Rights: As a patient, you have the right to access, copy or inspect your protected health information, or PHI, in accordance with federal law. You may also have the right to request an amendment to your PHI, or request we restrict the use and disclosure of it. These rights are further described in our Notice of Privacy Practices and in other policies which you may have upon request.

To better allow us to process your request, please indicated the type of request you are making on this form: [check all that apply]

________ Access to simply review my health information.

________ Access to obtain copies of my health information.

________ Access to review and potentially request amendment of my health information.

________ Access to review and potentially request an accounting of how my PHI has been used and disclosed to others.

________ Access to review and potentially request restrictions on the use and disclosure of my health information.

________ Other: (Please Explain): ____

Signature: ___________________________ Printed Name: _______________________

Relationship to Patient: _________________ ___________ Date: __________________

(If not the patient, please complete next page)

Please be advised Medical Information is confidential and may be released only upon written consent of the patient, legal guardian, or verified power of attorney. In cases involving personal representative, we require proper legal documentation. In the case of an expired patient, next of kin may sign the authorization, but proper court appointed legal documentation must be included, proving their right to obtain medical information.

Created: 5/2003 Revised: 12/2012; 12/2021

AUTHORIZED PERSONAL REPRESENTATIVE FORM

Patient Name: ____________________________ Date of Birth: _____________________

To be completed and signed by the Personal Representative*:

I, _________________________________ (*Please Print Name*), certify that I am a Personal Representative of the above patient because: *(Check the box or boxes that apply)*

____ The patient is under 18 years old, and I am the patient's parent or a person standing *in loco parentis* (in the place of the parent)

____ I am the agent listed in a Durable Power of Attorney for Health Care signed by the patient. *(Please provide the Company with a copy of the Durable Power of Attorney for Health Care.)*

____ I am the patient's

- ____ spouse
- ____ guardian *(Please provide the Company with guardianship papers.)*
- ____ parent (*Check here if you are the parent of the adult patient who is expired or otherwise incapacitated, and there is no other valid personal representative, i.e. spouse or court appointed guardian.)*

____ The patient is deceased, and I am the estate's executor or administrator. *(Please provide the Company with the documents confirming this information).*

____ Other: ____
(Such as patient's next of kin not listed above, a public health officer, etc.)

I certify the above information is true and correct,

_______________________________________ __________________________
Signature of Personal Representative **Date**

* Note: The Company can decide not to treat a person as the patient's Personal Representative if it has reasonable belief of abuse, neglect or endangerment.