Patient's Access to PHI Request Form

Patient Information (Please Print)

First Name	Middle Initial		Last Name	
Date of Birth	Phone		Email	
Street Address		City	State	Zip

Which records are you seeking?

☐ Physician Office Notes	☐ X-ray Images and/or Reports	☐ Physician Orders
☐ Laboratory Reports	☐ MY ENTIRE MEDICAL RECORD	☐ Other (specify)

If the PHI I am requesting contains information about drug/alcohol abuse, mental health treatment, HIV/AIDS testing or treatment or any other sensitive information, by signing this form, I confirm that I am requesting access to this information, unless I otherwise state here: ______________

Date(s) of Service Requested: From ___/___/______ To ___/___/______
(If dates of service are not specified, records will be provided for all dates of service)

I request that PHI be provided in the following format (if readily reproducible in this format):

☐ Paper Copy
☐ Electronic Copy via (check below)
- ☐ CD (for image requests only)
- ☐ Encrypted E-Mail (to e-mail address below)
- ☐ Unencrypted E-Mail (to e-mail address below)

I request that access to PHI be provided by the following method:

☐ Personal pick up at the following location/facility:	☐ Mailed to the following address:	☐ Faxed to the following fax number:
☐ Emailed by secure mail to the following email address:	☐ Emailed by unsecure mail to the following email address:	☐ Other (please specify):

ACKNOWLEDGMENT: I understand that the imaging CD is not encrypted and that I am responsible for protecting information on the CD. I also understand that unsecure/unencrypted e-mail is not secure and while in transit it can be intercepted and seen by others. By requesting to receive my PHI electronically on a CD or by unencrypted e-mail I acknowledge that I understand and accept these risks.

I understand that I may be charged a reasonable fee for the costs of labor for copying, postage, supplies as permitted by HIPAA Privacy Rule and state law.

Print Name	Signature
Date	**If this request is signed by the patient's personal representative,** specify above the personal representative's authority to act on behalf of the patient

***** To complete your request, please return the completed form via email to MedicalRecords@gohealthurgentcare.com or by mail to 5555 Glenridge Connector, Ste. 400, Medical Records Dept., Atlanta, GA 30342*****

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INTERNAL USE ONLY

Identity Verification Performed Via:

Photo ID: ☐ Yes ☐ No
Matching Signature: ☐ Yes ☐ No
Other (specify):_ ____
Personal representative documentation provided and reviewed: ☐ Yes ☐ No

Disposition of Access Request

Request ☐ Approved ☐ Denied (reason:_________________________________)
Processed by: ____
☐ Records Provided Pursuant to Request Date:_______________________
☐ Notice of Denial Provided to Patient Date:_______________________