



HIGH RESOLUTION
OUR FOCUS IS YOUR HEALTH

PATIENT ACCESS TO PHI

(Protected Health Information - To Include All Contents of the Designated Recorded Set)

This form must be completed when a patient is granted access to, or we send copies of his/her PHI to the patient.

Records are Requested From:

Patient Name: (First, Middle, Last)			
Address:		City	State
Zip		Date of Birth:	
Phone #:		Email Address:	

Please check all that apply:

<input type="checkbox"/>	I am requesting a copy of all of my medical records.		
<input type="checkbox"/>	I am requesting the following medical records.		
<input type="checkbox"/>	Radiology Reports	<input type="checkbox"/>	Lab Reports
<input type="checkbox"/>	Other: List		

I am requesting the records from:		to	
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Format of Records to be delivered: Paper CD Electronic Other: _____

Records will be Mailed Pick-Up Secure Electronic Transfer Emailed* Faxed*

Other:	
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Signed: Patient		Date:	
Signed: Patient Representative		Date:	

Power of Attorney Guardian Parent Other: _____

ID Provided:	
Request Taken By Phone (Verification)	

* Email and Fax are an insecure method of transmission and could be intercepted by other persons with access to the email/fax/electronic fax and the protected health information could be intercepted as it travels. We have advised the patient that we cannot guarantee at what date or time the information will be sent by our medical records personnel. Therefore, emailing or faxing their patient records could lead to unauthorized disclosure of their personal health records.

<u>RAA/HIRES Use Only</u>			
Fee Charged:		Date Records Delivered:	