

# Request for Access to Protected Health Information

Pursuant to 45 CFR § 164.524 · Also satisfies 45 CFR § 164.508

## Section 1: Patient Information

Patient Name

Date of Birth

Phone

Address (Street, City, State, ZIP)

Email

## Section 2: I Request Records From

Provider / Facility

Provider Address

## Section 3: Deliver Records To

Recipient Name

Recipient Address

Recipient Email

*If requesting records for yourself, enter your own name and address above.*

## Section 4: Information Requested

Complete Electronic Health Information (EHI) Export

All associated documents and images

Additional Description / See Appendix A if attached

## Section 5: Purpose

Personal use / At the request of the individual

Other:

## Section 6: Expiration & Patient Rights

This request expires one year from the date of signature, or upon fulfillment, whichever is first.

I may revoke this request at any time by written notice to the provider named in Section 2, except to the extent that action has already been taken in reliance on it.

My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this request.

Information disclosed under this request may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

## Section 7: Signature

Signature of Patient or Authorized Representative  
If signed by representative: describe authority (e.g., parent, guardian, POA)

Date