Request for Access to Protected Health Information

Pursuant to the HIPAA Right of Access, 45 CFR § 164.524

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: Acknowledgment

I understand that I may withdraw this request in writing at any time, except to the extent it has already been fulfilled. A photocopy or electronic copy of this request is as valid as the original.

Section 6: Signature

Signature of Patient or Personal Representative

Date

If signed by representative: describe authority (e.g., parent, guardian, POA)