

Patient Request for Access or Copies of Protected Health Information

Patient name _____

Patient date of birth _____

Patient social security number or health identification number _____

Name of patient's health care provider _____

Contact phone number _____

Your rights

You have a right to access, review, and obtain copies of your protected health information (PHI), which includes medical records, billing summaries, and other records that are currently used for making decisions about you. You have a right to see or receive copies of PHI upon request within 30 days. Please read this form carefully, mark the appropriate box, then sign, date and return this form **Attention: Compliance Manager** at the address or fax number shown above.

Access and inspection. Please call **(503) 291-7155** to make an appointment with the *Compliance Manager* to schedule a time during which you can access and inspect PHI. You are required to make an appointment to ensure that there is adequate space for you to privately review and inspect PHI. If you submit this form, someone will contact you to set up an appointment.

Photocopies or computer generated records. From: ___ / ___ / ___ To: ___ / ___ / ___ (Please indicate the period for which you are requesting copies, or write "ALL"). The charge for this service is \$25.00 for pages 1-10 and \$0.25 per page for pages 11-infinity. You will be contacted when the records are available. If you want PHI mailed to you, please indicate the address on the lines below. Please note, however, that payment for postage will be added to the total cost of preparing copies or a summary of PHI.

Street Address _____ City _____ State _____ Zip Code _____

By: _____ Date: _____
Signature of patient or personal representative

Print personal representative name: _____

Describe personal representative's authority: _____

Your provider's responsibilities

Federal and state laws, regulations and court order may prohibit providing you access to or copies of PHI. If this is the case, you will be provided a written explanation for any such denial. Please contact the *Compliance Manager* at **(503) 291-7155** if you have questions about this form or your privacy.

**DO NOT WRITE BELOW THIS LINE
FOR OFFICE USE ONLY**

Approved. 1 to 10 pages @ \$25.00 + Number of pages 11- infinity: _____ @ \$0.25 = \$ _____
+ Postage \$ _____ = Total Amount Due: \$ _____

Denied. Reason: _____

By: _____ Date: _____
Authorized Signature