



REQUEST ACCESS TO PERSONAL HEALTH RECORD

Patient Name: _____

Date of Birth: _____

Address: _____

Telephone#: _____

Unit#: _____

PART A: REQUEST FOR INFORMATION

Patient Contact Information

_____ Last Name First Name

_____ Mailing Address

_____ Telephone Number Date of Birth

If you are a substitute decision-maker, your contact information

_____ Last Name First Name

_____ Mailing Address

_____ Telephone Number

NOTE: *Include copies of documents that provide your authority as a substitute decision-maker.*

PART B: ACCESS REQUEST

Please describe what you need and include details that will help us locate the record (e.g. dates, name of health care provider, etc.)

How would you prefer to access this information? Please check off:

- Receive hard copies of originals
- Receive electronic copies of originals (please supply storage medium)
- Examine originals in the facility

Signature of patient
(or legally authorized person)

Print Name

Date

PART C: RESPONSE TO ACCESS REQUEST (For Internal Use Only)

Information Regarding Receipt and Initial Review of Request

_____ Date Request Received _____ Request Received By _____
_____ Date Physician / Health Care Provider Notified _____

Information Regarding Response

Date Response Issued _____

- Access request granted
- Access request not granted
- Access request granted in part

If complete access request was not granted, reason for refusing the request / part of the request:

- Patient notified of refusal of access and rights
- Notify the Director, Health Records if access has not been granted

Information Regarding Extension

If an extension to the access request response was required, please indicate:

Date of Extension	Reason for Extension	Date Patient Notified

Processed by:

_____ Signature _____ Name (print) _____ Title _____