REQUEST TO INSPECT OR COPY PHI

_____ I am requesting to inspect my protected health information (PHI).

_____ I am requesting a copy of my protected health information (PHI).

Name, address, telephone number, and email address to whom we are to forward copies of your PHI:

____

____

Information Requested
Please describe the information that you would like to inspect or copy:

____

____

Review Procedures
Your request to inspect or copy your protected health information will be reviewed, and we will contact you only if we cannot accommodate your request. If we deny your request, you may request that we review that decision. We may be legally prohibited from making certain information available to patients or patient representatives. Such information would include: psychotherapy notes, information related to legal proceedings, information that federal or state laws prevent us from disclosing, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, and information that was obtained under a promise of confidentiality.

Within the limitations of the law, we will make every effort to accommodate your request.

____
Name of Patient (Type/Print) Date of Birth

____
Signature of Patient Date

____
Signature of Patient Representative (if applicable) Date

____
Relationship of Patient Representative to Patient (if applicable)

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