



# REQUEST FOR ACCESS TO PERSONAL HEALTH INFORMATION

## **Information and Instructions**

We will provide you with access to your personal health record, unless a legal exception applies. We will review all health record access requests, and will make every effort to respond to your request in a timely fashion. Please complete Parts A and B of this form and forward to Health Information Services.

## **PART A: REQUESTOR INFORMATION**

### **Patient Contact information:**

\_\_\_\_\_  
Last Name                                      First Name                                      Initials

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
Telephone Number                                      Date of birth

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

\_\_\_\_\_  
Last Name                                      First Name                                      Initials

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
Telephone Number

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

## **PART B: ACCESS REQUEST**

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

- Receive hard copies of originals  
 Examine originals in the facility

Date: \_\_\_\_\_ Signed by: \_\_\_\_\_

Witness: \_\_\_\_\_

(relationship if signed by  
other than patient)