Compass Health Network

Patient's Request to Access Protected Health Information ("PHI")

I request my PHI from the following Facility: _____

Patient's Name: _____ **Date of Birth:** _____ **Client #** _____

Patient's Address: _____

Patient's Phone Number: _____

I request a copy of the following PHI: *(please check the boxes below)*

☐ Treatment/Wellness Plan	☐ Psychological Testing	☐ Psychiatric Assessments
☐ Discharge Summary	☐ Laboratory Reports	☐ History/Physical
☐ Consultation Reports	☐ Progress Notes	☐ Billing Statements
☐ Other *(specify)*		

Date(s) of Service of PHI Requested: From Date: _____ To Date: _____

(if dates are not specified, records will be provided for all dates of service)

IMPORTANT: I confirm that this information request may contain information about drug/alcohol use, mental health treatment, genetic information, sexually transmitted diseases, HIV/AIDS testing or treatment or any other sensitive information.

I request that PHI specified above be provided:

☐ To me

☐ To the following person/entity: _____

(Specify name and address of person/entity to whom you would like your PHI to be sent)

I request that PHI be provided in the following format (if readily reproducible in this format):

☐ Paper Copy

☐ Electronic Copy via

☐ PDF Attachment to E-Mail

☐ Other: _____

I request that access to PHI be provided by the following method:

☐ Personal pick-up at above specified facility by me ☐

☐ Personal pick-up at above specified facility by

(specify name and relationship to patient): _____

☐ Mailed to the following address: _____

☐ Emailed by **Secure Mail** to the following e-mail address: _____

☐ Emailed by **Unsecure Mail** to the following e-mail address: _____

☐ Faxed to the following fax number: _____

☐ Other: *(specify)* _____

Patient's Name:_____ **Date of Birth:** _____ **Client #:**_____

ACKNOWLEDGMENT: I understand that unsecure/unencrypted e-mail is not secure and while in transit it can be intercepted and seen by others. By requesting to receive my PHI electronically I acknowledge that I understand and accept these risks.

Printed Name: _____

Signature:_____

Date:_____

Access Requested By: *(Check One)*

☐ Patient ☐ Parent (for minors) ☐ Personal Representative

If this request is signed by the patient's personal representative:
Please specify your authority to act on behalf of the patient and attach supporting documentation:

_____

Acknowledgment of Personal Pick Up:

Records picked up by (name/signature)_____Date: _____

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INTERNAL USE ONLY

Identity Verification:

Verification via Photo ID: ☐ Yes ☐ No

Verification via Matching Signature: ☐ Yes ☐No

Other: *(specify)* _____

Authority Verification:

Personal representative documentation provided and checked: ☐ Yes ☐ No

Request: ☐ Approved ☐ Denied (reason:_____)

Processed by:_____Date: _____