Community Memorial Healthcenter

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

I hereby request Community Memorial Healthcenter to provide me with access to all protected health information about me that is maintained by Community Memorial Healthcenter. Specifically, I would like to:

- ☐ Inspect my protected health information
- ☐ Obtain a copy of my protected health information
- ☐ Obtain a summary or explanation of my protected health information
- ☐ Please mail the copy I requested to me at the address written below

Patient name: _____ Date of birth: _____

Address: _____

_____

Telephone: _____ Patient Number: _____

Information to be copied: _____

_____

Dates of treatment: From _____ To _____

(Write ***"all"*** if you want information for all dates of treatment)

I understand that I **may be charged a fee** for the preparation of a summary or explanation of my protected healthcare information. I also **may be charged a fee** for copying costs to obtain a copy of my protected healthcare information or to obtain a copy of the summary or explanation of my protected healthcare information. If I request to have the information mailed to me, I understand that I **may be charged a fee** for mailing costs.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

Relationship of Representative to Patient: _____

Please describe the Representative's authority to act on behalf of the Patient: _____

_____