THE EYE SITE of Hampton

PATIENT ACCESS TO PHI

(Protected Health Information – To Include All Contents of the Designated Recorded Set)

This form must be completed when a patient is granted access to or we send copies of his/her PHI to the patient or a 3rd party at the patient's request.

Patient Name: (First, Middle, Last)					
Address:		City		State	
Zip		Date of Birth:			
Phone #:		Email Address:			

☐	This record request is for records to be sent to the patient.
☐	This records request is to direct medical records to:

Please check all that apply:

☐	I am requesting all of my medical records.							
☐	I am requesting the following medical records.							
	☐	Visit Summary	☐	Lab Reports	☐	Medications List	☐	Radiology Reports
	☐	History & Physical	☐	Other: List				

I am requesting the records from:	Click here to enter a date.	to	Click here to enter a date.

Format of Records to be delivered: Choose an item. Other: _____

Records will be ☐ Mailed ☐ Pick-Up ☐ Emailed* ☐ Faxed

Other:	

Signed: Patient		Date:	
Signed: Patient Representative		Date:	

ID Provided:	
Request Taken By Phone (Verification)	

*-Patient must be warned that email is an insecure delivery method and records could be intercepted.

Practice Use Only			
Fee Charged:		Date Records Delivered:	

Step 7: Documentation: Compliance Officer Forms: Access Request