INDIVIDUAL REQUEST FOR PHI

This form constitutes an Individual's request for PHI (PHI) held by the Covered Entity. To obtain your PHI this form must be filled out in its entirety.

Name: (First/Middle/Last) _____
Address: (Street/City/State/Zip code) _____
Date of Birth: (Month/Day/Year) _____
Social Security Number: _____ Date of Request: _____

I REQUEST THE COVERED ENTITY TO PROVIDE ME ACCESS TO THE FOLLOWING PHI ABOUT ME:

☐ Mental Health Records
☐ Medical Records
☐ Billing Records
☐ Other _____

I REQUEST ACCESS TO MY PHI FOR THE DATES COVERING THE FOLLOWING TIME PERIOD(S):

From: (Month/Day/Year) _____ to: (Month/Day/Year) _____

I WOULD LIKE TO OBTAIN THE REQUESTED PHI IN THE FOLLOWING FORMAT:

☐ Electronic sent to the following address: _____
☐ Hardcopy sent to the following address: _____

_____

☐ Other: _____
☐ On-site inspection

I UNDERSTAND THE COVERED ENTITY MAY CHARGE A REASONABLE FEE FOR THE COSTS OF COPYING, MAILING OR OTHER SUPPLIES ASSOCIATED WITH MY REQUEST.

_____
Signature of Individual Date

IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE

_____
Signature of Personal Representative Date

_____
Legal Authority of the Personal Representative