Request for Access to Protected Health Information

Name: ________________________________ Date of Birth:_________

Request for Access

_____ I would like to access and inspect my Protected Health Information ("PHI").

_____ I would like Advanced Oral and Maxillofacial Surgery to send a copy of my PHI to:.

Name:_______________________________________.

Address: _____________________________________.

Phone: ___________ Fax: ___________.

_____ I would like a summary of my requested PHI..

Description of Records or Information to Access, Copied, or Inspected:

____

____

Inspection Period:

I request information regarding the following time period:

From: ________/________/_________ / To: ________/________/_________ /

Month / Day / Year Month / Day / Year

Copy Fees

I understand that Advanced Oral and Maxillofacial Surgery may charge me for making copies of my PHI. Advanced Oral and Maxillofacial Surgery may charge me 25 cents per page of PHI photocopied.

Your Rights Regarding This Request

- I understand that I must be provided with a signed copy of this document.
- I understand that Advanced Oral and Maxillofacial Surgery may deny my request to access my PHI, in whole or in part. If I am denied access, I may request a review of their decision by submitting a Request for Review of Denial of Access. Advanced Oral and Maxillofacial Surgery will designate another health care professional, who was not directly involved in the decision to deny access, to conduct a second review of my request.

Signature:____Date: _________

If signed by someone other than individual to whom the health information pertains, state the name, relationship, and authority to sign authorization on individual's behalf, and attach any supporting documentation to this request:

Name:______________________________________Relationship:________________