

Dr. Anthony Dohse & Dr. Robert Wolf  
Request for Access or to Disclose Protected Health Information

Policy Number: \_\_\_\_\_  
Effective Date: \_\_\_\_\_  
Last Revised: \_\_\_\_\_

[PATIENT] Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Request for Access or Transfer:** (Check which applies)

- I request access and/or copies of my Protected Health Information ("PHI").
- I request **Dr. Anthony Dohse and Dr. Robert Wolf** to transfer a copy of my PHI.

**If requesting a transfer, who will be receiving the requested PHI?** (Please provide the following information about the recipient.)

Name (a person or entity):	E-mail:
Street Address:	City, State, and or Zip Code
Telephone No.:	Fax No.:

**Description of Records or Information to Access or Copy:** (Specify type of disease, accident, dates of treatment, or other portion of information you are interested in)

\_\_\_\_\_

\_\_\_\_\_

I would like a copy of my PHI sent via the following method of transmittal: (Check only one)

- U.S. Mail
- In person pick-up by patient at the office
- Secured/Encrypted E-mail
- Unsecured/Unencrypted E-mail\*\*

\*\* I understand that I have requested Dr. Anthony Dohse and Dr. Robert Wolf transmit my PHI through unsecure/unencrypted e-mail. I have been warned that there are potential security risks to my PHI in the transmission of such unsecured methods and Dr. Anthony Dohse and Dr. Robert Wolf is not liable for any potential security risks such as unauthorized disclosures of PHI associated with the transmittal of such PHI through unsecure/ unencrypted e-mail. Further, Dr. Anthony Dohse and Dr. Robert Wolf is not liable for what happens to the PHI once the designated third party receives the information as directed by my access request. By signing below, I agree to accept the risk that my PHI is being sent via unsecure/ unencrypted e-mail.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CONFIDENTIAL AND PROPRIETARY INFORMATION

Policy Number: \_\_\_\_\_  
Effective Date: \_\_\_\_\_  
Last Revised: \_\_\_\_\_

**Copy/Postage Fees**

I understand that Dr. Anthony Dohse and Dr. Robert Wolf may charge me for making copies of my PHI. Dr. Anthony Dohse and Dr. Robert Wolf may charge me twenty-five cents (\$0.25) per page or fifty cents (\$.50) per page for records copied from microfilm. I further understand that you may charge me your reasonable actual costs for providing copies of any x-rays or tracings derived from electrocardiography (E.K.G.), electroencephalography (E.E.G.), or electromyography (E.M.G.), or impose a reasonable deposit fee as a condition of this transfer. If the requesting party requests that the copies be mailed, Dr. Anthony Dohse and Dr. Robert Wolf may charge for the cost of postage.

**Your Rights Regarding This Request**

- I understand that I must be provided with a signed copy of this document.
- I understand that Dr. Anthony Dohse and Dr. Robert Wolf 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. Dr. Anthony Dohse and Dr. Robert Wolf 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: \_\_\_\_\_