# Request to Access PHI

**Hanger Clinic** ***recognizes your right under HIPAA to access copies of your health information. You have the right to obtain and inspect copies of your clinical and/or billing records.***

**1. Patient Information (Please Print)**

| | | | |
|---|---|---|---|
| First Name: | Middle Initial: | Last Name: | |
| Date of Birth (MM/DD/YYYY): | Phone: | E-mail (optional): | |
| Street Address: | City: | State: | Zip: |

**2. What records do you want? (Check appropriate boxes below):**

☐ Clinical Records ☐ Billing Records Date(s) of Service:_____/_____/_____through_____/_____/_____

Clinic Location(s): 1. _____ 2._____

**3. In what form would you like your records delivered?**

☐ Paper: ☐ Mail Delivery ☐ In-Person Pickup

☐ PDF via *encrypted Email ☐ PDF via **unsecured Email ☐ Risk Acknowledged (check if requesting unsecured email)

** Unless requested otherwise, emails will be sent encrypted. Registration in our encryption system will be required.*
*** If you choose to receive an unsecured email, note that there are risks with sharing clinical information outside of an encryption environment. While we will make every effort to limit the identifying information about you in an email, we need you to acknowledge that risk.*

**4. Where do you want the information sent?**

Provide my records to: ☐ Self ☐ Personal Representative (Private individual only, non-commercial)

| | |
|---|---|
| Recipient Name: | Recipient Phone: |
| Recipient Mailing Address: | Recipient E-mail (if requested): |

**5. Please print your name and sign below:**

| | |
|---|---|
| | |
| **Name of Patient or Personal Representative (please print above)** | **Relationship (please print above)** |
| | |
| **Signature of Patient or Personal Representative** | **Date** |

**For Internal Use Only:**

☐ Request to Access PHI approved ☐ Request to Access PHI denied

Reason for Denial (if applicable)_____

Signature Hanger Clinic Representative: _____ Date:_____/_____/_____

Compliance Reviewed: February 2020