REQUEST FOR ACCESS FORM

The purpose of this form is to document a request for access to patient information.

Privacy Officer Name:  DH Clinic Operations Supervisor  Telephone:  231-591-2260

Patient’s Name: (print) ____________________________________________________________

Date of Birth: __________________________________________________(for identification purposes)

Describe the records you wish to access and the approximate dates of the records:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

What would you like for us to do for you?

I wish to see the requested records
☐ I wish to get a copy of the requested records
☐ I wish to see and get a copy of the requested records
☐ If the requested records are in an electronic designated record set, I wish an electronic copy of
  the requested records in the following format, if readily producible:
_____________________________________________________________________________________
_____________________________________________________________________________________

☐ If you would like the information emailed, enter the email address here (PLEASE PRINT VERY
  CLEARLY!) ____________________________________________________________

We do not recommend sending patient information in an unencrypted email because third
parties may be able to access the email.

☐ I want you to prepare a summary of the requested records and I agree in advance to pay a fee in
  the amount of $__________.
☐ I want you to prepare an explanation of the records that I saw or got a copy of, and I agree in
  advance to pay a fee in the amount of $ __________.

(See back of form for more information)
I want you to send the copy of the requested records to:

Name:
____________________________________________________________________

Address:
____________________________________________________________________

Fees

Our practice charges a reasonable, cost-based fee for the copies of patient information, and for postage to mail records if requested.

Questions?

Please contact our Privacy Officer listed at the top of this page if you have any questions about your privacy to inspect or copy records.

If the request is by a patient:

Patient Signature: __________________________________________ Date: _____________________

If the request is by a patient's personal representative:

Name of the Personal Representative: __________________________________________

Relationship to Patient: __________________________________________

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

Signature of Personal Representative:
____________________________________________________________________ Date: _____________________

For Dental Office Use Only

May need to consult with FSU General Counsel prior to making a decision.

☐ Request for access denied (attach written denial)
☐ Request for access approved