

Patient Request for Access

Hillsborough County Patient Request for Access to Protected Health Information

Patient Name:	P			
Street Address:				
City:	State:	Zip Code:		
Email:Date of Birth:				
Right to Request Access to	Your PHI and Our Duties			
	nmitted to protecting your pe 45 C.F.R. §§ 164.103, 164.1	ersonal health information under 105.	the HIPAA	
information ("PHI") that we format, then you also have a may request that we transm when required by law to do	e maintain in a designated re a right to obtain a copy of th it a copy of your PHI directl so. Requests to transmit PH), and clearly identify the des	to inspect or obtain a copy of you ecord set. If we maintain your Phat information electronically. In the state another person and we will! It to another party must be in wriginated person to whom the PH	HI in electronic addition, you honor that reques iting, signed by	
days of your request. We nauthority of the person to has security number, date of bir or other information necess circumstances, we may den	hay verify the identity of any ave access to the PHI by ask th, legal authority to act on lary to verify that the request y you access to your PHI, aronable cost-based fee for pro-	resentative) access to your PHI way person who requests access to be ing the requestor to provide the pubehalf of the patient (such as a potor has the right to access PHI. It and you may appeal certain types oviding you access to your PHI, so	PHI, as well as the patient's social ower of attorney) in limited of denials. We	
Request for Access to PHI	;			
Specify dates of service and	• •	access to with as much specificity Hillsborough Countyquest.	• •	
			_	



Specify How You Would Like us to Provide Access:

Please check	k all that apply and fill ou	at the requested infor	rmation, where indicated.				
	_ Please provide me w	ith a copy of my PH	П				
	_ Mail. Please send a	copy of my PHI to	me at the following address	SS:			
	Street:						
	City:	State:	Zip Code:	_			
	Format (paper copy,		sc, etc.):				
			o the following email add				
	Email address:			-			
	Format (PDF, Word,	Format (PDF, Word, etc.):					
		Please transmit a copy of my PHI to the following party at the following mailing address or email address in the specified format:					
	Designated Party:						
	Street:						
	City:	State	: Zip Code:				
	Email address:						
	Format (Paper, PDF,	Format (Paper, PDF, Word, etc.):					
	Department's place of	of business (Hillsbornient time and place	at Hillsborough County rough County for you to inspect a copy	Department			
Signature of	f Requestor:		Request Date:				
Requestor I	nformation (if requestor	is different from po	utient):				
Name:							
Relationship	o to Patient (parent, legal	guardian, etc.):					
Street Addre	ess:						
City:		State:	Zip Code:				