

# Patient Right of Access HIPAA Form

Under the Health Insurance Portability and Accountability Act (HIPAA), you have the right to access, inspect, and obtain a copy of your protected health information (PHI) maintained in a designated record set. Please complete the fields below to submit your request.

## 1. Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Email Address:

Mailing Address:

## 2. Records Requested

Please specify the health information you wish to access or obtain:

Dates of Service (e.g., From January 2022 to Present):

Specific Information Requested (e.g., Progress Notes, Lab Reports, Billing Records):

## 3. Form and Format of Access

Please specify how you would like to receive or inspect the records:

Format Choice (e.g., Paper Copy, Electronic PDF on CD, Secure Email):

## 4. Delivery Information

Please specify where the requested records should be sent:

Recipient Name (Self, Representative, or Third-Party Doctor):

Recipient Mailing Address or Email Address:

## 5. Patient Signature and Authorization

By signing, I request that the provider release the information requested above in accordance with HIPAA regulations.

Signature of Patient or Personal Representative:

Date (MM/DD/YYYY):

If Signed by Personal Representative, State Relationship to Patient: