REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Lauren C Swerdloff, MD

Patient Name:_____

Address: _____

Date of Birth: _____ Date of Request:_____

As allowed by the Privacy Regulations, I wish to access the following information contained in my protected health records: (*Please be specific*)

_____

I would like the following access:

☐ **Copies**. I would like copies of the above-listed information.

Format.

☐ I would like to receive the above-listed information in person.

☐ Or because of the following undue hardship:
_____

I would like to receive the records via certified mail return receipt.

Charges

I understand that I may be charged reasonable clerical costs and that you may charge postage, a copy or other fee associated with this request. I agree to pay these costs prior to receipt of the requested information. _____
Initials

Response

I understand that you will either grant or deny this request within the prescribed time period and the response will be in writing with an explanation as required by the Privacy Regulations.

_____ _____
Signature Date

_____ _____
Authorized Signature of Facility Date

