Patient's Request to Access Protected Health Information ("PHI")

Patient's Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Social Security #: _____

I request a copy of the following PHI:

✓ Physician Office Notes	✓ Laboratory Reports
✓ History/Physical	✓ Pathology Reports
✓ Consultation Reports	✓ Progress Notes
✓ Operative Reports	✓ Radiology Images
✓ X-Ray Reports	✓ Mammogram Reports

Date(s) of Service of PHI Requested: From 01/01/2020 to Present

IMPORTANT: If the PHI I am requesting contains information about drug or alcohol abuse, mental health treatment, genetic information, sexually transmitted diseases, HIV/AIDS testing or treatment or any other sensitive information, by signing this Patient's Request to Access PHI form, I confirm that I am requesting access to this information, unless I otherwise initial here: _____

I request that PHI specified above be provided to the following person/entity:
Dr. Jill Scherbel – Scherbel Clinic.

I request that PHI be provided in the following format:
Electronic Copy via email to Info@ScherbelClinic.com

ACKNOWLEDGMENT: I understand that unsecure/unencrypted e-mail is not secure and while in transit it can be intercepted and seen by others. By requesting to receive my PHI by unsecure e-mail I acknowledge that I understand and accept these risks.

Access Request by: ☐ Patient ☐ Parent (for minors) ☐ Personal Representative

Printed Name: _____ Date: _____

Signature: _____