REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

SECTION A: PATIENT TO COMPLETE THE FOLLOWING INFORMATION

DATE: _____

PATIENT NAME: _____ BIRTH DATE: _____

PATIENT ADDRESS: _____

PATIENT TELEPHONE NO.: _____ MED. REC. NO.: _____

REQUEST:

I hereby request that ECM provide me with (check all boxes that apply)

- ☐ My medical records.
- ☐ My billing records.
- ☐ Any other personally identifiable information used by ECM to make medical decisions about me. Please describe: _____
- ☐ I am interested in access to or obtaining a copy of all requested information maintained by ECM.
- ☐ I am interested in accessing or obtaining a copy of the requested information relating to the following time period: _____through_____

I wish to receive the requested information in the following format:

☐ Photocopies ☐ Electronic Transmission (if available) ☐ Other (if available) _____

Signature of the patient or legal representative _____

Printed name of the legal representative _____

Relationship to patient _____