

REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

Patient Name: _____
Last First MI Previous Name Date of Birth

I am requesting my records be sent to:

Name of person and/or facility

Street Address City State Zip

Phone Number Fax Number

Type of Records to Send:

2-year history unless otherwise specified: _____ to _____
(Month/year) (Month/year)

Type of Access Requested: ☐ Mail ☐ E-mail ☐ Fax (limited 40 pages)

☐ Secure email: _____

Provide E-mail address

☐ If you want your records sent in an un-encrypted e-mail and you understand and accept the risk of your PHI sent in this unprotected manner,
please initial here: _____

Initial

Provide E-mail address

☐ Mail the copies to: ☐ Self ☐ Other (list name) : _____

Address/City/State/ZIP: _____

☐ Inspection of my health information – Please contact Health Information Management at (319) 352-4930, to arrange a mutually convenient time.

Signature of Patient or Patient's Authorized Representative

Date

If signed by patient's representative, please PRINT representative's name and describe his/her authority.

Representative's name Authority: ☐ Parent of Minor ☐ Legal Guardian (Obtain Court document)
☐ Power of Attorney for Health Care (Obtain HCPOA document)
☐ Other _____

INTERNAL USE ONLY (Document PHI disclosed, date of disclosure and by whom)

Released by/Department: _____

Initials/Department

Date/Time

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