1600 S Taylor Ave
Springfield, IL 62703
Phone: 217-993-7701
Fax: 833-980-0314

Patient Request for Access Form

Patient Name: _____Date:_____

Address: _____

City: _____State:_____ZipCode:_____

Social Security Number: _____

Date of Service: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your protected health information, or PHI, in accordance with federal law. You may also have the right to request an amendment to your PHI, or request that we restrict the use and disclosure of it.

To better allow us to process your request, please indicate the type of request you are making on the form: (check all that apply)

___Access to simply review my health information.

___Access to obtain copies of my health information.

___Access to review and potentially request amendment of my health information.

___Access to review and potentially request an accounting of how my PHI has been used and disclosed to others.

___Access to review and potentially restrictions on the use and disclosure of my health information.

Signature _____Request Date_____