Patient Representative Access to Protected Health Information

SECTION A: Requestor to complete

Date: ____________________________ Requestor Name:______________________________________

Patient Name: _________________________________ Patient Date of Birth: _______________________

Address:____

REQUEST:
I request that GREEN APPLE THERAPY provide me with access to Protected Health Information (PHI) as checked below. **(Check all that apply)**:

____Referral documents
____Admission documents
____Advance directives
____Initial evaluations
____Re-evaluations
____Other (Describe below)
____Orders
____Visit notes
____Journal notes
____Discharge documents
____Insurance documents
____Detailed bill

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I request access to the health information above covering the dates

_______________________ through ______________________________. **(Please fill in dates).**

Type of Access Requested:

_____ Inspection of documents with GREEN APPLE THERAPY representative (no copies provided).

_____ Copies of information from GREEN APPLE THERAPY.

____ __________________________

Signature of Requestor Date

____
Print Name

____
Requestor's Title (e.g., Parent, Guardian, Foster Parent, Medical Power of Attorney)

***If your request for paper copies is granted, you will be charged a reasonable fee for printing and mailing. Digital copies are free of charge.*

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