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 THERAPY 2000 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

_____

_____

I request access to the health information above covering the dates
_____ through _____. **(Please fill in dates).**

Type of Access Requested:

_____ Inspection of documents with THERAPY 2000 representative (no copies provided).

_____ Copies of information from THERAPY 2000.

_____ _____

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.