Request for Access to Protected Health Information

Name: _____ Date of Birth:_____

Request for Access

_____ I would like to access and inspect my Protected Health Information ("PHI").

_____ I would like Emily Scholl DMD, PA, LLC to send a copy of my PHI to:.

Name:_____.

Address: _____.

Phone: _____ Fax: _____.

_____ I would like a summary of my requested PHI..

Description of Records or Information to Access, Copied, or Inspected:

_____

_____

Inspection Period:

I request information regarding the following time period:

From: _____/_____/_____/ To: _____/_____/_____/

Month / Day / Year Month / Day / Year

Copy Fees

I understand that Emily Scholl DMD, PA, LLC may charge me for making copies of my PHI. Emily Scholl DMD, PA, LLC may charge me 25 cents per page of PHI photocopied.

Your Rights Regarding This Request

- I understand that I must be provided with a signed copy of this document.
- I understand that Emily Scholl DMD, PA, LLC may deny my request to access my PHI, in whole or in part. If I am denied access, I may request a review of their decision by submitting a Request for Review of Denial of Access. Emily Scholl DMD, PA, LLC will designate another health care professional, who was not directly involved in the decision to deny access, to conduct a second review of my request.

Signature:_____Date: _____

If signed by someone other than individual to whom the health information pertains, state the name, relationship, and authority to sign authorization on individual's behalf, and attach any supporting documentation to this request:

Name:_____Relationship:_____