EVMS MEDICAL GROUP

ACCESS TO PROTECTED HEALTH INFORMATION - REQUEST FORM

REQUEST SECTION

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request the opportunity to inspect and/or obtain a copy of your protected health information for as long as the information is maintained by EVMS Medical Group. We will evaluate your request and will either grant it or explain the reason why the request will not be granted. If access is denied on grounds subject to review, you may request that the decision be reviewed by someone other than the person who originally denied the request.

I, _____ (print name) hereby request:

☐ access to; and/or

☐ a copy of the following heath information pertaining to me _____ maintained at:

_____

Department/Clinic

Patient's Date of Birth or SSN: _____

_____ _____

Signature *Date*

Personal Representative of
Patient:_____

Name *Signature* *Date*

Authority or relationship to Patient:_____

……

(Office use only)

REVIEW SECTION This section is to be completed by the reviewer:

Date Request Received:	**Request Reviewed by:**	**Date patient notified:**
Request Received by:	**Date of Request Review:**	**Person notifying patient:**

The above request is hereby:
Granted ___; Appointment time/date:_____ with _____

Name of staff member

Denied ___
If the request is denied, indicate the reason for the denial:

Reviewer's Comments:

_____