Dr. Scott E. LaBorwit
SELECT eye care

Request for Access to Protected Health Information

(Practice Information)
Patient Name: _____
Patient DOB: _____
Contact Information: _____

Under the Privacy Rule, you or your designated personal representative have the right to access your protected health information (PHI) for the purposes of inspection and/or obtaining a copy. There are certain conditions under which we are permitted to deny access to your PHI. If relevant, any conditions of denial will be explained to you.

☐ Inspection – Access to inspect PHI is provided on a scheduled basis. Please note that, due to privacy and risk management guidelines, original documents of PHI may only be inspected in the presence of one of our staff members and original materials may not be removed from the facility. Our receptionist can provide scheduling information for you at the time of your request.

☐ Copies – If you prefer to receive copies of your protected health information, we may charge a reasonable, cost-based fee. If a copy fee applies, the amount will be communicated to you at the time of your request.

☐ Release to Third Party – If you wish to release a copy of your records to a third party, please complete the following:

Who will be authorized to receive information (list the individual/entity who is to receive your PHI):

Individual/Entity Name: _____

Address: _____

Phone/Fax*: _____
Email*: _____

***Secure Communication** – Note that regular email and some fax transmission methods are not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate email or fax as your preferred method of disclosure if this is of concern to you.

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, send only the following:

_____

If applicable, please specify the format in which you would like copies of PHI provided to you, or your designated recipient. We will accommodate your request, if possible.

- ☐ paper copy
- ☐ electronic copy – preferred format: _____

This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification or cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations.

_____
Patient Name

_____ _____
Patient or Guardian Signature Signature Date