FAMILY Circle of Care

REQUEST BY PATIENT FOR ACCESS TO THEIR PROTECTED HEALTH INFORMATION

Patient Name: _____

Address:_____

Phone Number: _____Date of Birth:_____ Date:_____

I would like to:

- ☐ Access my Protected Health Information maintained by FCC
- ☐ Obtain a copy of my Protected Health Information

The specific information I would like to access or receive a copy of is as follows:

Discharge Summary	Laboratory Reports	Emergency Medicine Reports
Billing Statements	Dental Records	History & Physical Exams
Pathology Reports	Operative Reports	Diagnostic Imaging Reports
EKG	Radiology Reports	
Progress Notes	Entire Record	
Other _____		

I want access that covers the following time period:

- ☐ Please notify me when the information is ready to be reviewed
- ☐ Please notify me when the information is ready to be picked up at
- ☐ Please send the copies of my record to me at the above address
- ☐ Please send the copies of my record to me at the following address:

_____

_____

Signature of patient or representative

Date Relationship to patient (if representative: _____

When you have completed this form, please return it to the designated FCC Clinic Front Office
We will respond to your request within 30 days of receipt

Date received at FCC Front Office: _____