ClassicSleepCare LLC
Healthy Sleep. Beautiful Smiles.

Request for Access / Copy of Protected Health Information

The purpose of this form is to request access to or a copy of protected health information.

Date of Request: _____

Information on Person Requesting Access / Copy

Patient Name: _____ Date of Birth: _____

Patient Address: _____

_____

Medical Record/Set: _____

Action Requested

[ ] Access to Inspect Protected Health Information

[ ] Copy of Protected Health Information – Indicate Number of Copies _____.

Format Requested (Circle Desired Format): Summary Detail

Fees for Request

The following fee will be imposed to receive a copy of your protected health information:

$ _____

Acknowledgment of Request

I hereby acknowledge the above request and understand that I will be responsible for the payment of the above fee (if any) in connection with this request.

_____ _____

Signature of Patient or Legal Patient Representative *Date*

[Note: All requests will be honored within 30 days, unless an extension is required in which case the above request will not take longer than 60 days to fulfill.]

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[Do Not Write in Section Below – For Healthcare Provider Use Only]

Assigned To: _____ Date Delivered to Patient:_____

Extension Requested: [ ] Patient Notified: [ ] Request Denied: [ ]

Date Notified: _____ Reason:_____