Patient Request for Access to Personal Health Information

As a patient of ***Village Internal Medicine*** you are entitled under federal law to access your personal protected health information maintained in a "designated record set." In order to process your request for access to this information, please complete this form and submit it to the Privacy Officer. When received by the Privacy Officer, he or she will use the information to verify your identity and process your request. If you have any questions or concerns, please contact the Privacy Officer, Tracey Maness, at (910)483-8080.

Patient Name: _____ Birth Date: _____

Patient Number or SS#: _____ Date of Request: _____

You have the right to view your protected health information, obtain a copy of the information, or both. Please indicate below whether you wish to view the information only, obtain a copy, or both. If you select "copy", please indicate your method of delivery.

[ ] I would like to **view** my protected health information. I have/will schedule (d) an appointment with **Village Internal Medicine** to view my health information on _____. I understand **Village Internal Medicine** may have a staff member sit down with me as I review my health information.

[ ] I would like a **copy** of my protected health information.

[ ] I will return to **Village Internal Medicine** and pick up the copy when it is ready.

[ ] I consent to having _____ pick up my Protected Health Information for me. She/he understands that verification of their identification may be required by use of a picture ID, such as a driver's license.

Due to "minimum necessary" requirements I understand that I must be specific about the information that I am requesting. I have specified the exact records needed below. (Please include any applicable dates, x-ray or lab reports, and/or notes relating to specific conditions.)

_____

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I understand that **Village Internal Medicine** is given thirty days to process my request for access if my information is maintained on-site, sixty days if the information is maintained off-site, and that **Village Internal Medicine** may extend the deadline by an additional thirty days, if I am notified in writing of the extension. I further understand that my rights are limited to any information in my "designated record set" as defined in Section 164.501 of the Code of Federal Regulations.

By signing below, I acknowledge and agree to the above conditions.

_____ _____

Signature of Patient Date