Soundental
ASSOCIATES, PC

Patient Request for Access to Patient's Protected Health Information Records

Privacy Official Name: Susan Soltis Telephone: 203-932-5818

Patient's Name (print):_____

Date of Birth:_____(for identification purposes)

Describe the records you wish to access and the approximate dates of the records:_____
_____
_____

What would you like for us to do for you?

- ☐ I wish to see the requested records.
- ☐ I wish to get a copy of the requested records.
- ☐ I wish to see and get a copy of the requested records.
- ☐ If the requested records are in an electronic designated record set, I wish an electronic copy of the requested records the following form and format, if readily producible:_____

  If you would like the information emailed, enter the email address here (PLEASE PRINT VERY CLEARLY!): _____@_____

  We do not recommend sending patient information in an unencrypted email because third parties may be able to access the email.

- ☐ I want you to send the copy of the requested records to:

  Name: _____

  Address:_____

Questions?
Please contact our privacy official listed at the top of this page if you have any questions about your request to inspect or copy records.

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If the request is by a patient:

Patient Signature:_____ Date:_____

If the request is by a patient's personal representative:

Print the Name of the Personal Representative:_____

Relationship to the Patient:_____

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

Signature of Personal Representative:_____

Date:_____

For dental office use only:

- ☐ Request for access denied (attach written denial).
- ☐ Request for access approved.

If approved, describe below when and how access was provided. If an electronic copy was provided, describe the form and format of the electronic copy.

_____

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www.soundental.com