Request for Electronic Copy of Protected Health Information

Patient's Name: _____ Date of Birth: _____

I request that ***(Insert healthcare provider/clinic name)*** provide me with an electronic copy of my protected health information, described below, in the following form or format:

What file type would you prefer?

☐ MS Word ☐ PDF ☐ Other: _____

Other formats may not be readily producible. If the format you prefer is not available, we can provide you with another file type or with a paper copy.

How would you like to receive your information?

☐ Patient Portal ☐CD ☐USB

☐ Email Email Address: _____

Please Print Clearly (If we cannot read your email address, we will not send your records.)

Keep this box only if email is not encrypted, otherwise delete.

Please be advised that our email is not encrypted and may therefore be at risk of being accessible by unauthorized individuals. By checking the box below, you are acknowledging that you have been made aware of these risks and give your permission for this office to email your protected health information to the email address you have provided above.

☐ I acknowledge that I have been notified of the risk of unencrypted email.

Description of Protected Health Information to be disclosed:

☐ Healthcare information relating to the following treatment, condition, or dates of service:

_____

_____

☐ All healthcare information

☐ Other: _____

_____

_____

Signature of Patient: _____ Date: _____

Name of Personal Representative (if applicable): _____

Signature of Personal Representative: _____ Date: _____

Relationship to Patient: _____