

## Request for Access

This form illustrates how a dental practice might document a request for access to patient information.

Privacy Official Name: \_\_\_Dr. Denise Nguyen Telephone: \_\_\_703-847-6544\_\_\_\_\_  
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 prepare summary of the requested records and I agree in advance to pay a fee in the amount of \$\_\_\_\_\_.  
\_\_\_\_\_
- I want you to prepare an explanation of the records that I saw or got a copy of, and I agree in advance to pay a fee in the amount of \$\_\_\_\_\_.  
\_\_\_\_\_
- I want you to send the copy of the requested records to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

**Fees**

Our practice charges a reasonable, cost-based fee to for copies of patient information, and for postage to mail records if requested.

**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.

**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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