NEPHROLOGY ASSOCIATES
delawarekidney.com

Request for Access to Personal Health Information

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

❒ I would like a copy of my health information – I understand I may be charged a reasonable cost-based fee.
❒ I would like to review my health information.
❒ I would like for my health information to be provided to a third party:

- Name of third party: _____

Please specify the records included in this request:

_____

_____

Select the format you would prefer:

❒ Paper
- ❒ Mail to above address
- ❒ Will pick up at the practice

❒ Electronically
- ❒ Flash Drive/CD
- ❒ Email

❒ Fax Number: _____

- Email address: _____
- For **email communication**, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. By providing my email address I elect to receive email communication as requested.

❒ I would like a written summary of the requested information. I understand that I may be charged a reasonable cost-based fee.

You will receive notification regarding this access request no later than 30 days from the date received. There are limited circumstances in which your request may be denied, some of which you may have the right to request a review of the decision.

_____ _____
Signature of Patient or Personal Representative Date

*Description of Personal Representative's Authority (attach necessary documentation)