FORT WAYNE
NEURO PSYCHOLOGY

4306 E. State Blvd.
Fort Wayne, IN 46815
Phone: 260-460-3203
Fax: 260-460-3271

Request for Access to Protected Health Information

Under the Privacy Rule, you or your designated personal representative have the right to access your protected health information (PHI) for the purposes of inspection and/or obtaining a copy. There are certain conditions under which we are permitted to deny access to your PHI. If relevant, any conditions of denial will be explained to you.

- ❑ Inspection – Access to inspect PHI is provided on a scheduled basis. Please note that, due to privacy and risk management guidelines, original documents of PHI may only be inspected in the presence of one of our staff members and original materials may not be removed from the facility. Staff can provide scheduling information for you at the time of your request.

- ❑ Copies – If you prefer to receive copies of your protected health information, we may charge a reasonable, cost-based fee. If a copy fee applies, the amount will be communicated to you at the time of your request.

- ❑ Release to Third Party – If you wish to release a copy of your records to a third party, please complete the following with their information.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI):

Individual/Entity Name: _____

Address: _____

Phone/Fax*: _____/_____

Email*: _____

***Secure Communication** – Note that regular email and some fax transmission methods are not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate email or fax as your preferred method of disclosure if this is of concern to you.

Description of information to be disclosed – I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

- ❑ Entire patient record; **or**, send only the following:

_____

If applicable, please specify the format in which you would like copies of PHI provided to you or your designated recipient. We will accommodate your request, if possible.

- ❑ paper copy
- ❑ electronic copy – preferred format: _____

_____ _____

Patient Name **Patient Date of Birth**

_____ _____

Patient Signature or Authorized Representative Signature **Date**