## REQUEST TO INSPECT OR COPY PROTECTED HEALTH INFORMATION

**PATIENT:**

________________________________________ ________________
Patient Name/Previous Name(s) Date of Birth

________________________________________ ________________
Street Address, City, State, Zip Code Phone Number

**RELEASE MY PROTECTED HEALTH INFORMATION TO:** ☐ Myself ☐ Individual Noted Below

Individual Name ________________________________________

Business Office (if applicable): ______________________________

Street Address ________________________________________

City, State, Zip Code ____________________________________

Phone #____________________________Fax #____________________

## INFORMATION TO BE DISCLOSED

**Date(s) of Service:** ______________________________

___History & Physical
___Progress Notes
___Discharge Summary
___Consultations
___Operative Reports
___EKG Reports
___Laboratory Reports
___Pathology Reports
___ Radiology Reports
___ Radiology Images
___ Other_____________
____________________

____________________________________________________________
____________________________________________________________
____________________________________________________________

**We may be prohibited from making certain information available to you or to your representative, including**:

-Psychotherapy notes
-Information related to medical research in which you have agreed to participate
-Information related to legal proceedings
-Information obtained under a promise of confidentiality
-Information that federal or state laws prevent us from disclosing
-Information related to medical research in which you have agreed to participate
-Information for which the disclosure may result in harm or injury to your or to another person

**This information is to be**: ☐ Mailed ☐ Pickup ☐ Fax ☐ Inspect ☐ Email:________________

**Please choose format:** ☐ Paper Copy ☐ Electronic Media: ☐ Disc ☐ USB Drive ☐ Email

**YOUR RIGHTS WITH RESPECT TO THIS REQUEST:**

Within the limitations of law, we will make every effort to accommodate your request. We will complete our review of your request and as requested either provide a copy or arrange for you to inspect your records within 30 days of your request, or provide you with a written explanation of any restriction on the information that we can provide you.

__________________________________________________
Printed Name of Patient or Legal Representative

________________________________________ ____________
Signature of Patient or Legal Representative/Relationship Date

**Mailing Address: 1593 E Polston Ave, Post Falls , ID 83854 or Fax : 208-262-2382**