COASTAL RADIOLOGY ASSOCIATES, PLLC
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COASTAL IMAGING & VASCULAR ASSOCIATES
A division of Coastal Radiology Associates
1165 Cedar Point Blvd, Suite I
Phone: 910-353-3759 Fax: 252-393-1076

Request for Access to Personal Health Information

Patient Name: _____DOB: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Work Phone: _____

I request to access to my personal health information

- o I would like a copy of my health information
- o I would like to review my health information

Please specify the records you wish to review or obtain copies of:

_____

_____

Select the format you would prefer:

- o Paper _____ Please mail to above address _____ Will pick up at the practice*
- o Electronically _____ Flash Drive/CD* _____ Patient Portal _____ E-mail*
- o Fax Number: _____
- o I would like a written summary of the requested information.

***For Paper Records and/or Flash Drive/CD Requests:**
If I am unable to pick up my requested health information, I give permission to _____ to pick up and receive on my behalf.

***E-mail Option:**
If you chose the email option, please provide your e-mail address here: _____

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 e-mail address above, I elect to receive email communication as requested.
Patient Initials: _____

Please Note: *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.*

_____ Date _____
Signature of Patient or Personal Representative
*Description of Personal Representative's Authority (attach necessary documentation)

Forward this request to HIPAA Privacy/Security Officer

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