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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For office use only

Attach this form to: Request for Access to Personal Health Information

Patient Name: _____DOB: _____

Date Received: _____ By: _____

- Request Accepted
- Request Denied

If denied, provide reason(s):

_____
_____

Reviewable grounds:

- The access is reasonably likely to endanger the life or physical safety of the individual or another person.
  - This ground for denial does not extend concerns that the individual will not be able to understand the information or may be upset by it.
- The access requested is reasonably likely to cause substantial harm to a person (other than a healthcare provider) referenced in the PHI.
- The provision of access to a personal representative of the individual that requests such access is reasonably likely to cause substantial harm to the individual or another person.

Unreviewable grounds:

- Request is for psychotherapy notes, or information compiled in reasonable anticipation of, or for use in, a legal proceeding.
- An inmate requests a copy of their PHI and providing the copy would jeopardize the health, safety, security, custody, or rehabilitation of the inmate or other persons at the institution. An inmate retains the right to inspect their PHI.
- The PHI is part of a research study still in progress provided the individual agreed to the temporary suspension of access.
- The PHI was obtained by someone other than a health care provider (e.g., a family member of the individual) under a promise of confidentiality and providing access to the information. would be reasonably likely to reveal the source of the information.

Dates of Office Visits/Procedure Reports Released if not Entire Medical Record:

Dates:				
Visit Types:				

Dates:				
Visit Types:				

Date individual notified: _____ By:_____

Date information provided as requested

- Mailed: _____
- Emailed: _____
- Picked up in the office: _____
- Faxed: _____
- Placed on patient portal: _____
- Other: _____

Released By: _____

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