

# PATIENT REQUEST FOR MEDICAL RECORDS



You have the right to request a copy of your AKDHC/PKDHC Protected Health Information (PHI). Per the HIPAA Privacy Rule we have 30 days to process your request but our goal is to complete your request within 14 business days after receipt of the request. If we are unable to process your request within that timeline we will contact you.

Please complete the below information (any section that is left blank may delay our response to your request)

PATIENT INFORMATION			
Last Name	First Name		M.I.
Address	City	State	Zip
Date of Birth	Phone		

**Please identify your relationship to the patient:**

- Patient/Self
- Other (identify relationship to the patient and phone number): \_\_\_\_\_
- Check if patient is deceased

I am requesting records described below for the period: \_\_\_\_\_ to \_\_\_\_\_

Describe the personal health information you would like copies of: \_\_\_\_\_

- I want to pick up a copy of the requested medical records at the office: \_\_\_\_\_
- I want AKDHC/PKDHC to mail the requested medical records (identify address if other than the patient's address).

We may deny the request if:

- The patient's personal health information contains psychotherapy notes or is gathered to prepare for and use in a civil, criminal or administrative proceeding; or
- A licensed health care professional has determined that access to the personal health information is likely to endanger the patient's safety or the safety of another person; or
- The patient's personal health information refers to another person.

\_\_\_\_\_  
Patient or Legal Representative **Printed Name**

\_\_\_\_\_  
Patient or Legal Representative **Signature**

\_\_\_\_\_  
Date

If the above signature is the patient's Legal Representative complete the following:

LEGAL REPRESENTATIVE INFORMATION			
Last Name	First Name		M.I.
Address	City	State	Zip
Representative capacity (e.g. power of attorney, legal guardian, executor of estate):	Phone		

**Submitting a Request for Medical Records:**

All requests should be documented in writing and directed to the AKDHC/PKDHC Privacy Officer. Completed request forms should be mailed to the Privacy Office using the contact information below or handed to the office staff who will direct the request to the Privacy Office for you.

AKDHC Administration Attn: Privacy Officer  
3333 East Camelback RD Suite 180  
Phoenix, AZ 85018  
  
Phone: 602-997-0484

OFFICE USE ONLY:			
Request Received By:		Date:	