PATIENT REQUEST FOR MEDICAL RECORDS

You have the right to request a copy of your AKDHC Protected Health Information (PHI). 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: ____

Patients will be billed a $6.50 flat fee billable for all medical record requests. Additional fees may apply based on the volume of records produced for the request and the delivery method selected (postage will apply to all mailed records).

☐ I want my records emailed to me via secure email (provide email address): _________________________________
☐ I want AKDHC to mail the requested medical records (postage will apply)- identify address if other than the patient's address
____

AKDHC 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 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:	