PATIENT ACCESS REQUEST

Patient Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ **Main Contact Number:** (___) _____
☐ Home ☐ Cell ☐ Work

Mailing Address: _____
(Street) (City) (State) (Zip)

REQUEST TYPE

☐ I would like a copy of my health information provided by Northeast Digestive Health

RECORDS REQUESTED: ☐ Entire Record ☐ Other: _____

_____

FORMAT/DELIVERY – PATIENTS ONLY

☐ Paper ☐ Fax: _____

☐ Mail ☐ Pick up at practice ☐ Patient Portal

☐ Email*: _____

- I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk.
- This practice is not responsible for the privacy or security of your health information after it is sent to you or others listed on this form.

REQUESTS – ELECTRONIC FORMAT & DELIVERY TO THIRD PARTIES

☐ I would like a copy of my *electronic* health information to be *electronically* transmitted to a third party.

Transmit to: _____
Name Phone Secure Email/Fax/EHR

RECORDS REQUESTED: ☐ Entire Record ☐ Other: _____
These records must be sent using a secure connection.

We will let you know about this access request within 30 days after it is received by this office. There are limited situations where your request may be denied. You will receive a letter explaining the reason for any denial. You can ask for a review/appeal of a denied request for certain situations.

_____ _____
Patient or Personal Representative Signature Date

_____
Printed name and description of Personal Representative's Authority (e.g., healthcare power of attorney) Date

(Attach documentation to support the personal representative's authority if not already on file with the practice)