FOLEY EYE CLINIC PA
FORM 23010

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

I hereby request access to the protected health information about me that has been created or is maintained by **Foley Eye Clinic PA**.

INDIVIDUAL WHO IS THE SUBJECT OF THE PROTECTED HEALTH INFORMATION

Name: ________________________________ Date of Birth: ____/____/____ (mm/dd/yy)

Address: ____

City: ___________________________ State: ________ Zip Code: _____________________

Phone Number: ____

TIME PERIOD OF REQUEST

I am requesting access to the protected health information created or received by **Foley Eye Clinic PA** between:
____/____/____ and ____/____/____ (mm/dd/yy).

INFORMATION BEING REQUESTED

I am requesting access to the following protected health information: (describe the information as specifically as possible)

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LOCATION TO SEND THE INFORMATION

I am requesting that the protected health information be delivered to me as follows:

- ☐ I will pick up the copies of my protected health information;
- ☐ Please mail the copies of my protected health information to me; or
- ☐ Please mail the copies of my protected health information to my personal representative

Address for mailing copies of the protected health information:

- ☐ Please use the address provided above; or
- ☐ Please use the following address:

Name: ________________________________

Address: ____

City: ___________________________ State: ________ Zip Code: _____________________

PLEASE NOTE THE FOLLOWING:

1. We must act on this request within 30 days.
2. We may deny access to protected health information in certain situations and conditions. If you are denied access to any portion of the protected health information requested, we will notify you in writing of the reason for the denial. We will also inform you of any rights you may have to have the denial reviewed.
3. You may request a summary of the protected health information, if you agree to any cost associated with producing the summary.
4. We may charge a fee for copies of your records. The fee must be consistent with the attached form titled, "Maximum Charges for Copies of Patient Records." You may refuse to sign this authorization. Your refusal will **not** affect your ability to obtain treatment or payment.

   ☐ When this box is checked, **Foley Eye Clinic PA** will charge a fee for copying your records. The estimated fee will be $______.

Individual's (or Legal Representative's) Name: ____

Individual's (or Legal Representative's) Signature: ____

Date: ____________________

Capacity or Authority of Legal Representative* (if applicable):________________________________

*May be requested to provide verification of representative status.