THE CARE TEAM
Home Health & Hospice

ACCESS TO PROTECTED HEALTH INFORMATION REQUEST FORM

Patient Name: _____ **Date of Birth**: _____
Patient Address: _____ **Date**: _____

I *(Patient/Legal Representative Name)*_____request that The Care Team provide me with access to my Protected Health Information as checked below:

□ Entire medical record (all information)
□ Assessments
□ Business Office File
□ Diagnostic reports (lab, x-ray, etc.)
□ Medication and Treatment Records
□ History and Physical
□ Nursing documentation/progress notes
□ Physician and professional progress notes
□ Physician orders
□ Rehabilitative and restorative therapy documentation
□ Social services documentation
□ Other (be specific): _____
_____
_____

I request access to my health information as indicated above for the following dates:
From: _____ Through:_____

Type of Access Requested

□ Inspection of requested information with The Care Team medical staff
□ Copies of requested information maintained by The Care Team

Signature of Patient/Legal Representative: _____Date: _____
Printed Name: _____ Date: _____
Legal Representative Relationship to patient: _____

Distribution of copies: Original to Individual's record, copy to Individual