

Austin Gastroenterology, PA

**Request for Access to PHI (Protected Health Information)**

Patient Name: _____	Patient ID # _____
Address 1: _____	Date of Birth: _____
Address 2: _____	Home Phone: _____
City/State/Zip: _____	Work Phone: _____

I hereby request Austin Gastroenterology, PA to copy my following records and mail them to me at the address provided above:

Description of records to be copied: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I agree to pay Austin Gastroenterology, PA for the cost of copying and mailing the said records. Such cost is calculated to be: \$ \_\_\_\_\_.

I understand that:

- 1) I am entitled to inspect and obtain a copy of my PHI maintained by Austin Gastroenterology, PA.
- 2) I am required to make a written request for access to PHI using this form, which must be completed in order for Austin Gastroenterology, PA to provide me with the requested information.
- 3) Austin Gastroenterology, PA has the right to charge me for copying and mailing costs.
- 4) I have the right to request Austin Gastroenterology, PA to amend my protected health information (PHI) or record in the designated record set.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient's Representative  
(if applicable)

\_\_\_\_\_  
Relationship to Patient  
(if applicable)

FOR OFFICE USE ONLY:

Date Received: \_\_\_\_\_      \_\_\_ Request Accepted      \_\_\_ Request Denied

Reason for Denial (if applicable)

- Access is likely to endanger the life or physical safety of the individual or another person
- Psychotherapy notes
- The information is compiled for use in a civil, criminal, or administrative action or proceeding
- Other

Date Request Received: \_\_\_\_\_

Received By: \_\_\_\_\_

Date Payment Received: \_\_\_\_\_

Received By: \_\_\_\_\_

Date Request Fulfilled: \_\_\_\_\_

Fulfilled By: \_\_\_\_\_