INDIVIDUAL REQUEST FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form constitutes an individual's request for protected health information (PHI) held by the County. To obtain your PHI this form must be filled out in its entirety.

Name: (First/Middle/Last) ____________________

Address: (Street/City/State/Zip code) ____________________

Date of Birth: (Month/Day/Year) ____________________

Social Security Number: ____________________ Date of Request: ____________________

I REQUEST THE COUNTY TO PROVIDE ME ACCESS TO THE FOLLOWING PHI ABOUT ME:

- ☐ Mental Health Records
- ☐ Medical Records
- ☐ Billing Records
- ☐ Other ____________________

I REQUEST ACCESS TO MY PHI FOR THE DATES COVERING THE FOLLOWING TIME PERIOD(S):

From: (Month/Day/Year) ____________________ To: (Month/Day/Year) ____________________

I WOULD LIKE TO OBTAIN THE REQUESTED PHI IN THE FOLLOWING FORMAT:

- ☐ Electronic sent to the following address: ____________________
- ☐ Hardcopy sent to the following address: ____________________
- ☐ Other: ____________________
- ☐ On-site inspection

I UNDERSTAND THE COUNTY MAY CHARGE A REASONABLE FEE FOR THE COSTS OF COPYING, MAILING OR OTHER SUPPLIES ASSOCIATED WITH MY REQUEST.

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Signature of Individual Date

IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE

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Signature of Personal Representative Date

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Legal Authority of the Personal Representative