FERRIS STATE UNIVERSITY
College of Health Professions

REQUEST FOR ACCESS FORM

The purpose of this for is to document a request for access to patient information.

Privacy Officer Name: DH Clinic Operations Supervisor Telephone: 231-591-2260

Patient's Name: (print)_____

Date of Birth: _____(for identification purposes)

Describe the records you wish to access and the approximate dates of the records:
_____
_____
_____.

What would you like for us to do for you?

I wish to see the requested records

- ☐ I wish to get a copy of the requested records
- ☐ I wish to see and get a copy of the requested records
- ☐ If the requested records are in an electronic designated record set, I wish an electronic copy of the requested records in the following format, if readily producible:
  _____
  _____.
- ☐ If you would like the information emailed, enter the email address here (PLEASE PRINT VERY CLEARLY!) _____

  We do not recommend sending patient information in an unencrypted email because third parties may be able to access the email.

- ☐ I want you to prepare a summary of the requested records and I agree in advance to pay a fee in the amount of $_____.
- ☐ I want you to prepare an explanation of the records that I saw or got a copy of, and I agree in advance to pay a fee in the amount of $ _____.

(See back of form for more information)

☐ I want you to send the copy of the requested records to:

Name:

_____

Address:

_____

Fees

Our practice charges a reasonable, cost-based fee for the copies of patient information, and for postage to mail records if requested.

Questions?

Please contact our Privacy Officer listed at the top of this page if you have any questions about your privacy to inspect or copy records.

If the request is by a patient:

Patient Signature: _____ Date: _____

If the request is by a patient's personal representative:

Name of the Personal Representative: _____

Relationship to Patient: _____

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

Signature of Personal Representative:

_____ Date: _____

For Dental Office Use Only

May need to consult with FSU General Counsel prior to making a decision.

☐ Request for access denied (attach written denial)
☐ Request for access approved