

Request for Access to Protected Health Information



I or my Personal Representative hereby request that Liberty Dayton Regional Medical Center provide access to my health information as described in this form. I am making this request under the provisions of the Health Insurance Portability and Accountability Act ("HIPAA") that entitle me to access my own health information including directing it to another person or entity (45 CFR 164.524)

Section A : Please complete the following information for all requests

Patient Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____

I hereby request that Liberty Dayton Regional Medical Center provide me with: (Check all that apply)

Access to Copy of the Requested Information Checked below:

- My Medical records
- My Billing Records
- I am requesting the following specific dates:

I am only interested in accessing or obtaining a copy of the requested information for the given time frame:

____ / ____ / ____ through ____ / ____ / ____

I am interested in accessing or obtaining a copy of all requested information maintained by Liberty Dayton Regional Medical Center

What format do you wish to receive this information?

Photocopies (Paper) Electronic (If available) Other: _____

Signature of Patient or legal representative: _____

Date: _____

Printed Name of Personal Representative: _____

Relationship to Patient: _____