UNIVERSITY MRI & Diagnostic Imaging Centers

Request for Access to Protected Health Information PHI

Patient's Name: _____
(Print Name)

Patient's Date of Birth: _____ SS #: ___-__-____

Patient Phone#: _____ Patient Fax#: _____

As required by the Health Information Portability and Accountability Act (HIPAA) of 1996 you have a right to request the opportunity to inspect and copy health information that pertains to you that is in our designated record set. University MRI & Diagnostic Imaging Centers will evaluate your request and will either grant it or explain the reason why the request will not be granted and explain any review or appeal rights you may have.

I hereby request copies of the following PHI maintained by University MRI & Diagnostic Imaging Centers:
☐ REPORT ☐ CD ☐FILM ☐ OTHER: _____
DATE:_____ TYPE OF SERVICE_____
DATE:_____ TYPE OF SERVICE_____
DATE:_____ TYPE OF SERVICE_____
DATE:_____ TYPE OF SERVICE_____
DATE:_____ TYPE OF SERVICE_____

_____ _____
Signature of Patient **Date**

☐ I will pick up the requested PHI.

☐ I authorize _____ to pick up the requested PHI.
(Print Name)

☐ Mail to: _____
(Address)

FOR OFFICE USE ONLY
Date Received: _____ Reviewed By: _____

The PHI Request for access is: ☐Granted ☐Not Granted
If the request is not granted the HIPAA compliance officer must indicate the reason, sign and date.

_____ _____
HIPAA Compliance Officer Signature Date

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