



800 State Hwy 248, Suite 2D, Branson, MO 65616

Patient's Request to Access Protected Health Information (PHI)

IMPORTANT:

If my record contains information regarding drug/alcohol abuse, mental health treatment, HIV/AIDS testing or treatment, genetic information, communicable diseases or other sensitive information, I request that such information be included with my records:

- Yes (Include with my records)
- No (Do not include with my records)

I request my PHI, including that of which is specified above, be provided:

- To myself
- To the following people or entities:

(Specify name(s) and address(es) of person(s) or entities to whom you would like your PHI to be shared with)

Name(s)	Address(es)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ACKNOWLEDGEMENT:

By signing below, I give my permission to use and disclose my health information to the people and entities I have listed. I understand that I may add or remove names from the list I have provided at any time with the assistance of a Hill Family Chiropractic representative. I also understand that I may be charged a reasonable fee for the costs of labor for copying, postage, supplies as permitted by HIPAA Privacy Rule and state law.

Patient or Legally Authorized Individual Signature _____
Date

Print Patient's Full Name