

BOUNTIFUL DRUG

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Request to Access Protected Health Information Form

Name of Patient (PHI Requested for)	DOB
Name of Person Making Request (if not Patient)	Relationship to Patient (if not Patient)
Address	Telephone Number
Reason for Request	Brief Description of PHI Requested (Dates & Medications to include)
Preferred Format of PHI __ Paper Copy: __ Mail __ Pick-up __ Digital Copy: __ Email __ Fax	

I hereby represent and warrant that I am requesting access to Protected Health information (PHI) for myself or as the authorized representative of the Patient. If I am not the Patient, I have the full right and legal authority to make such requested and receive the PHI herein requested on behalf of the patient noted above, and I agree that I will use and disclose the PHI only as permitted by the patient and applicable privacy laws.

Signature

Date