Margaret Huggins, MD
Christopher Allphin, MD
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REQUEST FOR ACCESS TO PATIENT'S HEALTH INFORMATION

Please allow approximately one week to process your request after completing this form.

Requested By:

Name of Patient: ______________________ DOB: ____________

Address: ______________________ Phone No: ____________

City, State, Zip: ______________________ SSN: ____________

Records to Come From:

Name: ______________________ Phone No: ____________

Address: ______________________ Fax #: ____________

City, State, Zip: ______________________ Date Records Required: ________

To be released to: circle one: Mail Fax I will Pick up Records

Name: ______________________ Phone No: ____________

Address: ______________________ Fax #: ____________

City, State, Zip: ______________________ Date Records Required: ________

Reasons for Request: [] Changing Doctors/Practices [] another Doctor Consultation [] for own Use

Requested Records: [ ] Entire Chart [ ] Partial Chart-Date Range: __________ to ____________

[ ] Labs: ______________________________

______________________ ______________________
Printed Name of Patient or Representative if patient is a minor   Relationship

______________________ ______________________
Signature of Patient or Representative if patient is a minor   **Picture ID required upon pick-up of PHI**

______________________ ______________________
Witness   Date of Request

As a patient, you are entitled under Federal law to access your **Personal Health Information (PHI).** Your records are protected and cannot be disclosed without your written permission. If you have any questions or concerns regarding the handling of your PHI, or if you wish to view your PHI, contact our Privacy Officer at (208) 535-0440.

2990 Cortez Avenue ♦ Idaho Falls, ID ♦ 83404
(208) 535-0440 ♦ Fax (208) 535-0550