View Point Health

REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

CLIENT NAME *(FIRST, LAST)*
DATE OF BIRTH *(MM/DD/YYYY)*
SOCIAL SECURITY NUMBER
ADDRESS *(STREET, CITY, STATE, AND ZIP CODE)*

Use this form to request access to your Protected Health Information (PHI) maintained by View Point Health (VPH). This form applies only to VPH records and not those held by other providers.

Do not use this form to authorize disclosure to another person or entity.

Incomplete or incorrect forms may result in delays or denial of your request.

Please select ONLY ONE of the following:

☐ I am requesting **copies of my PHI**.

☐ I am requesting access to **inspect my PHI**.

Please describe the PHI that you are requesting access to with as much specificity as possible:
Specify dates of service and other details that will allow VPH to accurately fulfill your request

I REQUEST THAT THE PHI SPECIFIED ABOVE BE PROVIDED IN THE FOLLOWING METHOD:

☐ Mailed to the following address:

*We will automatically send emails through **encrypted/secure** means unless otherwise instructed. Unencrypted email carries some risk, such as third parties viewing the information without consent. We are not responsible for unauthorized access to unencrypted emails containing confidential information or any risks (e.g., viruses) that may be introduced to the device used to view such information.*

Emailed by ☐ **Encrypted Mail** or ☐ **Unencrypted Mail** to the following e-mail address:

REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

By completing and signing this access form, I understand that:

1. A team of licensed healthcare providers will review the PHI I have requested to assess whether providing access could endanger my life, physical safety, or the safety of others, and may deny my request if necessary.
2. **View Point Health will process my request within 30 calendar days** or 60 days after if the PHI I am requested is not available electronically or onsite.
3. If I am requesting to inspect/review my PHI, I will be contacted to schedule an appointment during VPH's regular business hours.
4. I (or my authorized representative) may be subject to criminal penalties pursuant to 42 U.S.C. 1320d-6 if I knowingly and in violation of HIPAA obtain individually identifiable health information relating to an individual or disclose individually identifiable health information to another person.
5. I understand **there are fees for producing my records**. I agree to pay these fees and I will receive my records after the payment is successfully processed.

_____ _____

REQUESTOR SIGNATURE DATE

_____ _____

AUTHORIZED REPRESENTATIVE (PRINT NAME) RELATIONSHIP

NOTE: **If you are signing as the legal (authorized) representative, you must submit a copy of the appropriate legal document(s) granting you the authority to do so. Examples would be a health care power of attorney, advanced directives for healthcare, letters of guardianship, etc. A** FINANCIAL OR BUSINESS POWER OF ATTORNEY IS NOT SUFFICIENT.

RETURN COMPLETED FORM:

View Point Health Medical Records Department
P.O. BOX 687
Lawrenceville, GA 30046

Email: medicalrecords@vphealth.org

Your request cannot be processed without a valid photo ID and any required supporting documents. If these are not submitted, your request will be denied, and you will need to submit a new request.