Request for Health Information Copy, Amendment, and/or Disclosures

Patient Information:

Patient Name:_____

Date of Birth:_____

Phone Number:_____

Email Address:_____

Address:_____

City: _____

State: _____

Zip: _____

Legal Guardian Name (if not patient requesting):_____

Legal Guardian Relationship to Patient:_____

Request:

☐ I would like to obtain a copy of my health record

☐ I would like to amend my health record

☐ I would like to obtain an accounting of disclosures of my health record

Request Details: Please provide any additional details relevant to your request._____

Signature of Patient or Legal Guardian:_____

Date:_____

Please email this completed form to info@phixnetwork.org or fax to 844.833.6810. Our team will respond within 15 business days. Please note that PHIX will likely need to contact you and/or your health providers directly in order to fulfill your request.