EMMA ECCLES JONES
COLLEGE of EDUCATION and HUMAN SERVICES
UtahStateUniversity

CEHS Request/Authorization to Access Protected Health Information

Patient Identification

Printed Name: ____

Address: ____

Telephone: __________________________ Date of Birth: __________________

Information to Be Accessed – Covering Date of Service or the Period of Health Care

From (date) ________________________________ to (date) _________________________

I am requesting access to (please check one):

☐ View Records Only	☐ Obtain copies of Records

If requesting copies, please describe the reason for the reason for the request:

☐ Further Medical Care ☐ Other: __________________________________	☐ Personal Use	☐ Insurance ☐ Legal

Describe the information you are requesting to View or obtain copies of:

☐ Evaluation ☐ Treatment Notes ☐ Medications	☐ Entire Medical Record ☐ Mental Health Records ☐ Other:

I certify that this request to access health information is made voluntarily and that the information given above is accurate. I understand that CEHS may not be able to grant me access to certain types of health information. I understand that if I need to obtain hard copies, there may be a charge associated with such copies.

Signature of Patient/Legal Representative: __________________________ **Date:** ___________

If Legal Representative, Print Name: ____

Relationship to Patient: ____

Office Use Only: Individual Who Received Request: _____________________________ Date: ________

Verification of Identity (DL or other ID): ______________________ Medical Record #: _____________

Request: Approved: ______ Denied: ______ Date Approved/Denied: ______________________

Date Fulfilled (Copies given/Records Inspected): ____________ Individual Who Fulfilled: _____________________

Reason for Denial (if applicable): ____

Effective Date: September 27, 2016