



Health Information Management

PO Box 9746 | Portland, ME 04104 | Phone (207) 791-3728 | Fax (207) 828-2433

Patient right of access request form

Patient Name: _____ **Date of Birth:** _____

I am requesting a copy of my Protected Health Information (PHI) from Martin's Point Health Care pursuant to the HIPAA Right of Access regulations.

Be aware health records may include sensitive information such as mental health, substance use, or HIV.

Indicate Information Being Requested:

- ☐ Date Range of Records ____/____/____ to ____/____/____
- ☐ Office Visits _____ Labs Date _____ Radiology Date _____
- ☐ Immunizations/Medication List Only
- ☐ Other (please provide details) _____

Format (select one): ☐ US Mail ☐ Flash drive ☐ Fax ☐ Email

Contact Information if Records to be Sent (patient or designated entity/individual):

Name: _____

Mailing Address: _____

City, State, Zip: _____

Email: _____ Phone Number: _____

Date/Time: _____ Patient Signature: _____

Relationship (if other than patient): ☐ Parent ☐ Guardian ☐ Health Care POA

IMPORTANT INFORMATION: I understand that if I ask Martin's Point Health Care to disclose PHI to another individual or entity, that information may no longer be protected by Maine and Federal privacy laws, including HIPAA. I understand that Martin's Point Health Care will make reasonable attempts to produce the documents in the format requested; however, if the records are not readily reproducible in that format, I understand Martin's Point Health Care will call to discuss alternative delivery options. In certain limited circumstances, Martin's Point Health Care may deny a request. If a request is denied, I understand I will be given a written explanation, and a description of steps I may take in response to the denial.