



## HIPAA Privacy Rights Request Form

### PATIENT INFORMATION

_____			Date _____	
Name (Last, first, middle initial) _____			Social Security # or Patient ID _____	
Street address _____		City _____	State _____	ZIP Code _____
Primary phone number _____	Other phone number _____	E-mail address _____		

### Type of Request

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Access/copy                | <input type="checkbox"/> Amendment                 | <input type="checkbox"/> Restriction |
| <input type="checkbox"/> Confidential communication | <input type="checkbox"/> Accounting of disclosures | <input type="checkbox"/> Complaint   |

Please describe nature of action requested (type of information requested; nature of amendment, restriction, alternative communication, or complaint, etc.) **in detail**.

*[Note: If this is an alternative communications request, please list alternative location/address for receiving medical information below.]*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list [Company Name] staff members that were contacted regarding this matter:

_____ Name	_____ Date	_____ Name	_____ Date
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Signature \_\_\_\_\_ Date \_\_\_\_\_

**For Administrative Use Only:** Date received \_\_\_\_\_

Action taken \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

Action taken \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

Privacy Official signature \_\_\_\_\_ Date \_\_\_\_\_

[Attach additional documentation, if applicable.]