McLaren Medical

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

I, _____, request McLAREN MEDICAL GROUP to permit me to access, inspect and/or obtain copies of certain information maintained in my designated record set, as follows (description of information): _____
_____
_____
_____
_____
_____
_____

I request that McLAREN MEDICAL GROUP provide me with access to my protected health information in the following format: _____

I agree that McLAREN MEDICAL GROUP may provide me with a summary or an explanation of my protected health information requested, if applicable.

I request that I may ❑ Inspect such information.
❑ Obtain copies of such information.

I understand and agree that McLAREN MEDICAL GROUP may impose a reasonable, cost-based fee for copying, including the costs of supplies and labor, postage, and preparing an explanation or summary of my protected health information, if requested.

Signature: _____ Date: _____ / _____ / _____

For Office Use Only:

Received Request for Access of Information on: _____ by: _____.

Department: _____

Patient Name:

Date of Birth: