



## REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

*The Ridge*

I hereby request The Ridge Ohio to provide me with access to all protected health information about me that is maintained by The Ridge Ohio. Specifically, I would like to:

Inspect my protected health information

or

Obtain a copy of my protected health information

I would like to:

Pick up the copy I requested

Mail to me at the address written below.

Receive my information on paper

Receive my information by flash drive,

Receive my information via e-mail.

Client Name: Date of Birth:

Client's Address:

Client's E-mail address:

Client's Telephone: Client Number:

Dates of treatment: From to

(Write "all" if you want information for all dates of treatment)

If I ask to have the information mailed to me, I understand that I may be charged a fee for mailing costs. If I ask for an electronic copy of my protected health information, I understand that I may be charged a fee for the media (flash drive) on which my copy is stored and provided to me and for the labor costs associated with making the copy. I understand that all fees charged will be consistent with the fees charged in the community for these services. I understand that The Ridge Ohio requires that I pay the required fee before the paper or electronic copy may be furnished to me. The Ridge Ohio will notify me of the fee. I understand that if The Ridge Ohio provides a hard copy of my protected health information, The Ridge Ohio will provide black and white and not color copies. If I ask to have information e-mailed, I understand that sending e-mails is not always secure, and I agree that I will not hold The Ridge Ohio responsible if the information e-mailed is intercepted by an unauthorized third party.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of person signing if other than Patient:  Guardian  Authorized Representative:  
\_\_\_\_\_ (attach copy of legal documents)

Date: \_\_\_\_\_

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