REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

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: _____