Request to Access Protected Health Information (PHI)

I, _____

hereby grant

_____

access to the protected health information (PHI) of my minor child, for whom I am the parent or legal guardian. I understand that, as the child's legal representative, I am entitled to access my child's PHI in accordance with applicable federal and state law.

I understand that the requested records may be accessed through one or more of the methods listed below. In the event that I am unable to visit the Agency in person, I request that a copy of my child's PHI be provided to this individual for the period of _____.

❑ I prefer the individual to come in person to the Agency to retrieve the copy of the requested medical.information.

❑ I prefer to have the requested information copied and mailed to the individual at the following address:

_____

❑ I prefer for the individual to receive a electronic copy of of the requested information.

Note: For paper copies of records, a nominal fee may be imposed by the Agency, that is not to exceed the cost of the supplies, labor and postage.

_____ _____

Signature Of Requestor Date

Pursuant to 45 CFR § 164.524(b)(2), the Agency (Sanctum Health Partners, LLC) is required to act on this request no later than 30 days from receipt. If the Agency is unable to fulfill this request within that time frame, a written explanation of the delay and the expected completion date must be provided in accordance with federal law.