Central Montana Medical Center

Patient Request for Access to Health Information

Please Complete Sections A – D

Requests for access will be acted on within 30 days of receipt of the request, if there is a delay in processing this request you will be provided with a written statement of the reasons for the delay.

A

Name:		DOB:
Address:		
City:	State:	Zip:
Phone:		

B

Request is for:	
☐ Copy of Health Information	Dates of Service:
☐ Access to Health Information	_____

C

Copy or Access to Health Information

First Copy free, subsequent copies 25 cents per page for paper copies; Electronic copy fees dependent on electronic form and format requested

Payment due prior to receipt of information

Information requested & reason for request:

Please select appropriate format:

☐ Paper Copy ☐ Review Only ☐ Electronic

If ELECTRONIC COPY BEING REQUESTED please describe media and format being requested:

_____

D

Authorization to Provide

Patient Signature: _____ Date/Time: _____

Witness Signature: _____ Date/Time: _____

2nd Witness Signature: _____ Date/Time: _____

If necessary for phone consents

To be completed by CMMC Personnel

DISPOSITION

☐ Request Granted ☐ Request Denied

Reason for Denial: _____

Employee Signature: _____ Date/Time: _____

MRC 6.3 11/78; R 11/88; R 4/03; R 9/13; R 10/17