

Tuscola County Health Department (TCHD)
Request for Access to Protected Health Information (PHI)

Date: _____

Name of Individual: _____

Social Security #: _____ Birth date: _____

Address: _____

I hereby request (check one or both):

- Access to my: A copy of my: An electronic copy CD (if applicable) of my
 An electronic copy email (if applicable) sent to the following email

_____ @ _____ of my:

Protected Health Information contained in the _____
_____ (designated record set). If I receive copies of
the Protected Health Information, I agree to pay a fee, per copied page, of my Protected Health
Information in accordance with the TCHD Fee Schedule. I understand that the TCHD is not
responsible for subsequent uses and disclosures made by me of information that has been released
to me by your practice.

Signature of Individual or Personal Representative: _____

Relationship to individual: _____

For Tuscola County Health Department Use Only:

Date received: _____ Date access/copies provided: _____

Has a restriction been placed on the PHI? Yes (see Nrsg. Admin) No

Brief description of Protected Health Information disclosed to the individual: _____

Format provided: Hard copy Electronic copy CD (if applicable) Access

Electronic copy encrypted email sent to (if applicable) _____ @ _____

Was any information withheld from the individual? Yes No

If yes, provide a general description of the information withheld and the reason for withholding it:

Name of staff member _____ Title: _____

Signature of health care practitioner: _____ Date _____