

Request for access to protected health information

Patient's Name (print): _____

Date of Birth: _____

Describe the records you wish to access and the approximate dates of the records:

What would you like for us to do for you?

- I wish to see the requested records.
- I wish to get a copy of the requested records.
- I wish to see and get a copy of the requested records.
- If the requested records are in an electronic designated record set, I wish an electronic copy of the requested records in the following form and format: _____

Fees

Our practice charges a reasonable, cost-based fee to for copies of patient information (\$0.55 per page and \$25.00/hour of preparation labor), plus postage or other fees consistent with providing records in the form and format of your election.

- I want you to prepare summary of the requested records and I agree in advance to pay a fee in the amount of \$_____.
- I want you to prepare an explanation of the records that I saw or got a copy of, and I agree in advance to pay a fee in the amount of \$_____.
- I want you to send the copy of the requested records to:

Name: _____

Address: _____

Questions?

Please contact our privacy official, Dr. Chad Stevenson, if you have any questions about your request to inspect or copy records.

Update June 12, 2021



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Please note that this form does not grant instantaneous access to records. While all responses will be given within a 30-day window, we aim to respond to all requests as soon as possible. Internal security policies are in place to prevent the unauthorized access to protected health information; depending on the nature of your request, these can take time.

If the request is by the patient to which these records belong to:

Patient Signature: _____ Date: _____

If the request is by a patient's personal representative:

Records requested by a personal representative must undergo additional approval prior to the release of records.

Print the Name of the Personal Representative: _____

Relationship to the Patient: _____

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

Signature of Personal Representative: _____

Date: _____

For dental office use only:

Requested reviewed by: _____ D.D.S.

Request for access denied.

Request for access approved. Describe below when and how access was provided. If an electronic copy was provided, describe the form and format of the electronic copy below.

Update June 12, 2021

Chad Stevenson D.D.S.
Andrew Stevenson D.D.S.
Jori May D.D.S.

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