

Request for Access to Patient's Health Information

As a patient of **SDMI**, you are entitled under federal law to access your personal protected health information maintained in a "designated record set." In order to process your request for access, please complete this form and submit it to the Privacy Officer, Sanaa Makram, CHC, SDMI, 2950 S Maryland Parkway, Las Vegas, NV 89109.

Name		Date of Birth	
Street Address	City	State	Zip Code
Telephone Number		Cell Number	
Date of Request			

Description of Records Requested:

Scope of Request:

I would like to inspect my Medical Record (SDMI will have a staff member with me while I inspect my records)

I would like a copy of my Medical Record

SDMI may charge me a fee for the copies at \$ _____ per page. I also understand that I may be required to pay the fee in full before I can obtain the copy.

I would like to both inspect and copy the request records

Other: _____

Delivery Method

I will return to SDMI and pick up the copy when it is ready.

I would like SDMI to send a copy via US mail to my address or: _____

I would like SDMI to give me a copy in an electronic format

I would like SDMI to provide me with a summary of the information provided. I understand there may be a fee involved.

I understand that **SDMI** is given thirty days to process my request for access if my information is maintained on-site, sixty days if the information is maintained off-site, and that **SDMI** may extend the deadline by an additional thirty days if I am notified in writing of the extension. I further understand that my rights are limited to any information in my "designated record set" as defined in Section 164.501 of the Code of Federal Regulations. By signing below, I acknowledge and agree to the above conditions.

Signature of Patient or Patient's Representative _____
Date

(If Personal Representative, please provide proof of identity and/or describe authority):