ASHEVILLE UROLOGICAL ASSOCIATES

PATIENT REQUEST FOR PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____
Name at time of Treatment (if different than above): _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____

What protected health information do you want? (Check appropriate boxes below):

Name of Physician: _____

Specific Treatment Dates: _____ to _____
☐Consultation Reports ☐Diagnostic Films ☐Dosimetry Records ☐Laboratory Results ☐Physician Dictation
☐Portal Films/Simulation Films ☐Progress Notes ☐Radiology or Imaging Reports ☐Surgery/Pathology
☐Complete Medical Record ☐Billing Records
☐Other (please specify): _____

How would you like your protected health information delivered?
☐Paper format: ☐CD/flash drive (*For paper/CD/flash drive select one*): ☐ Home Delivery ☐ In-person pickup
☐Secure Email ☐Unsecure email* ☐Portal ☐Other: _____

** Information delivered through email is inherently unsecure unless it is fully encrypted. Requesting that my records are sent to an unsecured email address is not a secure delivery method and there is risk that my health information may be intercepted and/or viewed by unauthorized persons. 21st Century Oncology and its affiliates, are not responsible for a third party's unauthorized access to my personal health information delivered in this format or any risks (e.g., virus) potentially introduced to my computer/device when receiving personal health information through unsecure email.*

I request that my protected health information (PHI) from 21st Century Oncology be sent to:
☐Self ☐Personal Representative (indicated address below)

Recipient Name: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____
Fax (healthcare provider only): _____

Patient/Authorized Representative
Signature*_____Date_____Time_____

Printed Name of Authorized Representative: _____

Relationship to Patient: _____

*If signed by a patient-authorized representative, supporting legal documentation must accompany this authorization form.

Driver's License or Photo ID (*required when records are picked up*) Driver's License State: _____Number: _____

_____Date_____Time_____
Witness Signature

Send completed form to: _____
_____
_____

21st Century Oncology recognizes a patients' right under HIPAA to access copies of his/her health information.
There may be charges associated with processing a request and producing requested record