Request Copy of PHI/EPHI/HEALTH RECORD

Patient Name: _____

DOB: _____/_____/____ Practice Name : **South Boston Dental Associates**

Date Requested: _____

Please provide specific details and dates:

_____

_____

_____

_____

_____

_____

Patient Signature (or authorized individual): _____

Printed name: _____

If authorized individual, relationship to patient: _____

FOR INTERNAL USE

__ **Accepts*** __ **Denies** __ **Accepts in part (see comments below)**

Date Received: _____

Privacy Officer or Designated Staff Signature: _____

Date of Review: _____

Additional Comments: _____