AMITY PHYSICAL THERAPY

Patient Request to Access Protected Health Information

Patient Name: ________________________________ Date of Birth: ______________________

I request that the facility provide me with access to my personal health information as circled below:

1) Medical Records
2) Billing Records
3) Other _____________________________

I request access to my health information covering the date's _____________ through ____________.

Specify number of copies requested: ________________

I understand that Amity Physical Therapy may charge a fee for the costs of copying, mailing or other supplies associated with my request.

Please mail information to:____

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Signature of Patient or Patient's Authorized Representative: __________________________________
Date: __________________________________

If signed by the Patient's Representative, please print name and describe relationship to the patient:

Name: _________________________________

Relationship to Patient: ___________________________________