Bridgepoint
Sinai Health System

ACCESS REQUEST FORM TO PERSONAL HEALTH INFORMATION

We will provide you with access to your personal health record, unless a legal exception applies.

Part A: Requestor Information

Patient Contact Information

_____ _____ _____
Last Name First Name Initials

_____
Mailing Address

_____ _____
Telephone Number Date of Birth

_____
Hospital ID Number

If you are a substitute-decision-maker, your contact information.

_____ _____ _____
Last Name First Name Initials

Note: Include copies of documents that provide your authority as a substitute decision-maker.

Part B: Access Request

1. Please describe what you need and include details that will help us locate the record (e.g., dates, name of healthcare provider, etc.)
   _____
   _____
   _____

2. How would you prefer to access this information? Please check off:

   ____ Receive hard copies of originals

   Please state reason for request_____

   ____ Examine originals in the facility.

Signature_____ Date_____

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Part C: Response to Access Request (For Internal Use Only)

1. Information Regarding Receipt and Initial Review of Request

_____
Date Request Received

2. Information Regarding Response

_____
Date Response Issue

____ Access request granted
____ Access request not granted
____ Access request granted in part

If complete access request was not granted, reason for refusing the request/part of the request.

_____

3. Information Regarding Extension
If an extension to the access request response was required, please indictate:

_____ _____ _____
Date of Extension Reason for Extension Date Patient Notified