



## Ear, Nose and Throat Associates

### Request for Access to Protected Health Information

I am requesting access to:

- Inspect, or
- Obtain a copy of my health care information maintained in my designated record set by Ear, Nose and Throat Associates.

Full Name of Subject Individual: \_\_\_\_\_

Address of Subject Individual: \_\_\_\_\_

Birthdate of Subject Individual: \_\_\_\_\_

Please provide specific dates or occurrences that will specifically identify the information you are requesting: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

If you need assistance in the completion of this form or have any questions regarding this process, please contact Medical Records and any necessary assistance will be provided.

Signature of Subject Individual: \_\_\_\_\_

Date: \_\_\_\_\_

If request is made by another legally authorized person, please state relationship/legal authority enabling you to act on behalf of the subject individual:

Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Processed by: \_\_\_\_\_