UTRGV UT Health Rio Grande Valley	Category: HIPAA Privacy Manual Policy Number: 15.012C Effective Date: April10, 2024 Last Reviewed: April 1, 2024 Page 1 of 2
Title: REQUEST FOR ACCESS, COPIES, OR INSPECTION OF HEALTH RECORDS	
Reference: 45 C.F.R. §§ 160.202, 164.504(e)(2)(ii)(F), 164.504(f)(2)(ii)(F),	

REQUEST FOR ACCESS, COPIES, OR INSPECTION OF HEALTH RECORDS

Please complete this request to ensure we understand your request for health information. If you are not the patient, you will be requested to provide proof of identity and your relationship to the patient or other legal authority you possess to obtain or inspect the health information.

Patient's Name: _____ Patient's Address: _____

Please check one which type of access to health records you are requesting:

☐ I request a copy of the patient's health records. I understand there is a charge for copying, which is $ _____ per page. I understand I am required to pay the charge for copying and any costs of postage before the copies are released to me.

☐ I request a summary of information in the patient=s health records, at a charge of $_____. I understand I am required to pay the charge and any costs of postage before the summary is given to me.

☐ I request to personally inspect the patient's health records at no charge, at a mutually convenient time.

Please check the type of information you are requesting and any specific dates or types of treatment.

☐ Billing and payment information
- If you only need certain dates or types of treatment, please describe:

_____

☐ Medical Record
- If you only need certain dates or types of treatment, please describe:

_____

☐ A summary of the medical record
- If you only need certain dates or types of treatment, please describe:

_____

I confirm that I am the

☐ the patient
☐ the patient's authorized representative, my relationship to the patient is _____

_____ _____ _____
Signature Name Date