Anchor Health - Hamden
2200 Whitney Ave, Suite 290
Hamden, CT 06518

Anchor Health - Stamford
30 Myano Lane, Suite 16
Stamford, CT 06902

PATIENT REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Please complete this form to request access to protected health information (PHI) from Anchor Health Initiative Corp. *("Anchor Health").*

Patient Information:

Date of Request:	*Month:*	*Day:*	*Year:*
Last Name:	**First Name:**	**MRN:** *(staff-use)*	
Legal Name: *(if different)*	**Date of Birth:**	*Month:*	*Day:*	*Year:*
Physical Address:	**Apartment:**		
City:	**State:**	**Zip Code:**	

What records and information do you want to access? *(check the appropriate boxes)*

☐ All medical records, including information/records received from other health care providers or other third parties; **or**

☐ Only the following information from my medical records, including information from other health care providers or others:

- ○ My record for treatment of: *(specify diagnosis or symptom)* _____
- ○ Laboratory results
- ○ Medication/prescription records
- ○ Billing records
- ○ Other: *(specify record type)* _____

Sensitive Information

The following information will not be released without specific authorization. To authorize release, please initial next to the information to be released.

Mental health information: _____ **Substance use disorder information:** _____

HIV-related information: _____

What dates are covered by this request? *(check the appropriate box and provide information, if applicable)*

☐ All dates of treatment ☐ Limited to the following dates: _____

(Continued on the next page)

How would you like the records delivered? *(check the appropriate boxes and provide information, if applicable)*

☐ Paper copies (***Note:*** *Paper copies may only be provided to patient or legal representative; complete Authorization Form for delivery to third party.)*

- ○ Delivery to patient/representative at following address: _____
- ○ Fax to patient/representative at following number: _____
- ○ In-person pick-up

  Location for Pick-Up: ☐ Hamden office ☐ Stamford office

☐ Electronic copies

- ○ Email to patient/representative at following email address: _____
- ○ Email to third-party at following email address: _____
- ○ USB/flash drive:
  - ☐ Delivery to patient/representative at following address: _____
  - ☐ Delivery to third party at following address: _____
  - ☐ In-person pick-up by: ○ Self/representative ○ Third party: *(specify name)* _____

    Location for Pick-Up: ☐ Hamden office ☐ Stamford office

Acknowledgements

I have read this request or had it explained to me, and I understand and agree to its contents.

Name of Patient: *(PRINTED)*	**Date:**
Signature:	
Name of Person Signing: *(PRINTED)*	

If not signed by patient, please check off the basis for your authority to sign this Consent:

☐ Parent of minor ☐ Guardianship order ☐ Power of attorney ☐ Conservator of person ☐ Other: _____

If this authorization includes the release of information for services obtained by a minor without parental consent, as permitted under state law (e.g., STD or HIV-related treatment), the minor must sign if a parent/guardian signed above:

Name of Minor/Client: *(PRINTED)*	**Date:**
Signature:	

Please note that Anchor Health recognizes a patient's right under HIPAA to access their health information. *There may be charges associated with producing requested records. Information on applicable charges is available at our offices.*