Pajka Eye Center Access to Protected Health Information Request Form

Use this form to request access to or to receive a copy of your protected health information that Pajka Eye Center maintains regarding you.

Name: _____ Phone Number: _____

Address_____
Street City State Zip Code

Date of birth: _____ Date of Request:_____

Description of records requested (please describe specific information or records requested and include time period):

Scope of request:
There is a cost-based charge for copying records as follows: The first copy is free, and there is a cost-based charge for copying records thereafter as follows: Pages 01-10: $3.51/pg, pages 11-50: $0.73/pg, Pages 51+: $0.29/pg.

I would like to inspect the requested records.
I would like to obtain a copy of my requested records.
I would like both to inspect and to obtain a copy of the requested records.
Other:

Signature of individual or personal representative: _____ Date:_____

If personal representative, describe authority and provide documentation and proof of identity:

_____

For Pajka Eye Center, Privacy Officer Use Only:
Identity of individual or personal representative verified: Yes No

Request approved.
Request denied.
Response delayed.

Response due date: _____
Comments:

_____
Signature of Privacy Officer Date

08/30/13
Rev. 03/04/19
Rev. 07/08/19
Rev. 08/27/19
Rev. 08/10/22