

Chippewa Valley Vein Center

1720 Harding Avenue, Suite #1

Eau Claire, WI 54701

PHONE: 715-832-2200 FAX: 715-834-1666 WEBSITES: [*www.cvveincenter.com*](http://www.cvveincenter.com)[*www.mxcimaging.com*](http://www.mxcimaging.com)

**Request for Access to Protected Health Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I request access to the following information:**

* Entire Medical Record
* On-site record review
* Billing Record
* Office Notes (specify dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Diagnostic Studies (specify dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other as listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Select the format you would prefer:**

* Paper \_\_\_\_\_ Please mail to above address \_\_\_\_\_ Will pick up at the practice\*
* Electronically \_\_\_\_\_ CD\* \_\_\_\_\_ Patient Portal \_\_\_\_\_ E-mail\*\*
* Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* I would like a written summary of the requested information.

**\*For Paper Records and CD Requests:**

If I am unable to pick up my requested health information, I give permission to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to pick up and receive on my behalf.

**\*\*E-mail Option:**

If you chose the email option, please provide your e-mail address here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that if my health information is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. By providing my e-mail address above, I am electing to receive my health information via email regardless of the risk.

**Please Note:** *Your request will be processed no later than 30 calendar days from the date received. You will be notified if additional time is needed to complete your request. There are limited circumstances in which your request may be denied. You have the right to request a review of the decision.*

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Signature of Patient or Personal Representative

\*Description of Personal Representative’s Authority (attach necessary documentation)