University of Iowa

Patient Request to Access Protected Health Information

Patient Name_____________________________ Date of Birth___/___/____

Date of Request___/___/____

I request that University of Iowa provide me with access to my personal health information as described below:

____
____
____

I request access to my personal health information covering the dates of ___/___/____ through ___/___/____.

Type of access requested:

- ❑ **Copies of requested information** (please specify the format you desire)
  - ❑ Hard Copy
  - ❑ Other_____________________

I understand that University of Iowa may charge a fee for the costs of copying, mailing, preparing a summary or other supplies associated with my request.

Please contact me at the following telephone number to arrange inspection or copying:
Telephone number: ____________________
e-mail: ______________________________
hours preferred: _______________________

____ ___/___/____
Signature of Patient of Patient's Authorized Representative Date
If signed by the patient's Representative, please print the name and describe relationship to the patient:

_______________________________ ________________________
Print Name Relationship

You will receive a response within 30 days of the receipt of your request.