BOULDER MEDICAL CENTER, P.C. - PROTECTED HEALTH INFORMATION MANAGEMENT FORM
PLEASE PRINT

Patient Name:_____ Medical Record #_____

Date of Birth:_____ Date of Request:_____

As allowed by Privacy Regulations, I wish for this office to record the following changes regarding my Protected Health Information. This request remains current until a new written request is submitted.

Access to Medical Records

☐ The following individuals may have access to this medical record (listed above) and may speak on my behalf:

Name	DOB	Relationship	Phone #

☐ Other Instructions_____

_____

Denial of access to Medical Records

☐ The following individuals are denied access to this medical record (listed above) and may not speak on my behalf:

Name	DOB	Relationship	Phone #

☐ Other Instructions_____

Alternative Communication Method

☐ I am requesting the following method of communication:_____

The Boulder Medical Center, P.C. has the right to deny any of these requests. If that is determined to be necessary, an authorized representative will notify you in writing within 30 days of this request.

_____ _____
Signature of Patient or Authorized Patient Representative Date

_____
Printed name of staff verifying the above information is correct and legible

Original of this form must be submitted to Release of Records at Broadway within 3 business days of request.
Release of Records will update your medical records within 7 business days of request.
This form will be scanned into your Medical Record and then will be destroyed.

RPP001a Rev03/15