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. This form will be scanned into your Medical Record and then will be destroyed.

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 (only complete if you are rescinding previous access)

☐ 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____

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The Boulder Medical Center 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

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

Receptionist: Update EMR by selecting the HIPPA tab; in the Privacy notes section update scanning information with the code "A34", the date and your initials.
Scan this form into patient's chart under scan code A34 and then destroy this form.

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