Company:_____
Address:_____
_____

*Privacy Officer:*_____
Phone:_____
Email:_____

HIPAA Privacy Rights Request Form

PATIENT INFORMATION

_____
Date

_____ _____
Name (Last, first, middle initial) Social Security # or Patient ID

_____ _____ _____ _____
Street address City State ZIP Code

_____ _____ _____
Primary phone number Other phone number E-mail address

Type of Request

☐ Access/copy ☐ Amendment ☐ Restriction
☐ Confidential communication ☐ Accounting of disclosures ☐ Complaint

Please describe nature of action requested (type of information requested; nature of amendment, restriction, alternative communication, or complaint, etc.) **in detail**.

[Note: If this is an alternative communications request, please list alternative location/address for receiving medical information below.]

_____
_____
_____
_____

Please list [Company Name] staff members that were contacted regarding this matter:

_____ _____ _____ _____
Name Date Name Date

Signature _____ Date _____

For Administrative Use Only: Date received _____

Action taken _____
_____ Date _____
Action taken _____
_____ Date _____

Privacy Official signature _____ Date _____

[Attach additional documentation, if applicable.]