Artise Dental
Request for Access or to Disclose Protected Health Information

Policy Number: _____
Effective Date: _____
Last Revised: _____

[PATIENT] Name: _____ Date of Birth: _____

**Request for Access or Transfer:** (*Check which applies*)

I request access and/or copies of my Protected Health Information ("PHI").

I request Artise Dental to transfer a copy of my PHI.

**If requesting a transfer, who will be receiving the requested PHI?** (*Please provide the following information about the recipient.*)

| | |
|---|---|
| Name (a person or entity): | E-mail: |
| Street Address: | City, State, and or Zip Code |
| Telephone No.: | Fax No.: |

**Description of Records or Information to Access or Copy:** (*Specify type of disease, accident, dates of treatment, or other portion of information you are interested in*)

_____

_____

I would like a copy of my PHI sent via the following method of transmittal: (*Check only one*)

U.S. Mail
In person pick-up by patient at the office
Secured/Encrypted E-mail
Unsecured/Unencrypted E-mail**

** I understand that I have requested transmit my PHI through unsecure/unencrypted e-mail. I have been warned that there are potential security risks to my PHI in the transmission of such unsecured methods and Artise Dental is not liable for any potential security risks such as unauthorized disclosures of PHI associated with the transmittal of such PHI through unsecure/ unencrypted e-mail. Further, Artise Dental is not liable for what happens to the PHI once the designated third party receives the information as directed by my access request. By signing below, I agree to accept the risk that my PHI is being sent via unsecure/ unencrypted e-mail.

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Signature: _____ Date: _____

**Copy/Postage Fees**

I understand that Artise Dental may charge me for making copies of my PHI. Artise Dental may charge me twenty-five cents ($0.25) per page or fifty cents ($.50) per page for records copied from microfilm. I further understand that you may charge me your reasonable actual costs for providing copies of any x-rays or tracings derived from electrocardiography (E.K.G.), electroencephalography (E.E.G.), or electromyography (E.M.G.), or impose a reasonable deposit fee as a condition of this transfer. If the requesting party requests that the copies be mailed, Artise Dental may charge for the cost of postage.

**Your Rights Regarding This Request**

- I understand that I must be provided with a signed copy of this document.
- I understand that Artise Dental may deny my request to access my PHI, in whole or in part. If I am denied access, I may request a review of their decision by submitting a Request for Review of Denial of Access. Artise Dental will designate another health care professional, who was not directly involved in the decision to deny access, to conduct a second review of my request.

Signature: _____ Date: _____

If signed by someone other than individual to whom the health information pertains, state the name, relationship, and authority to sign authorization on individual's behalf, and attach any supporting documentation to this request:

Name: _____ Relationship: _____