

**Amherst Pediatric Associates (APA)
Request for Inspection of Protected Health Information (PHI)**

(Please Print)

Patient Name: _____ D.O.B. _____

Patient Address: _____

I _____ as a patient of APA as the parent of a minor child who is a patient of APA do hereby request to inspect my protected health information (PHI). I want to inspect:

1. My entire medical record _____.
2. Only that part of my medical record that relates to:

_____.

I understand that this request will be reviewed by the APA Privacy Officer and a date and time will be arranged for me to review the record. This will occur at the offices of APA and under the direct observation of the Privacy Officer or a designated staff member.

I further understand that my medical record belongs, by law, to Amherst Pediatrics, who has created and maintained it, and may not be removed from the office, nor can the record be altered without my formally requesting an amendment to the record, if it's thought to be incomplete or inaccurate.

Under law, there are certain cases where APA cannot release some of my PHI for inspection and I will be advised in writing if this be the case.

Signature of Patient or Personal Representative of Patient

Date

For Practice Use Only:

Date inspection request received _____

Date inspection request granted _____ Denied _____

Date inspection occurred _____

Staff Supervisor _____

Signature of Privacy Officer

Date