Dialysis Clinic, Inc.
A Not-For-Profit Corporation

PATIENT'S/PATIENT REPRESENTATIVE REQUEST FOR AND ACKNOWLEDGEMENT OF RECEIPT OF PROTECTED HEALTH INFORMATION (PHI)

A. PATIENT'S REQUEST FOR PHI

I,_____, am a patient/patient representative (Circle One) at DCI. I am requesting a copy of the following portion(s) of the DCI records containing PHI:

_____
(List specific types of records and dates of service)

_____

_____

_____ _____
Patient/ Patient Representative Name (Printed) Witness Name (Printed)

_____ _____
Guardian's Name, if applicable (Printed) Witness Signature

_____ _____
Patient/Patient Representative/Guardian Signature Witness Title

_____ _____
Date Date

B. ACKNOWLEDGEMENT OF RECEIPT OF COPIES OF MEDICAL RECORDS

I,_____, have received copies of all the information I requested from DCI as written in the above portion of this form.

_____ _____
Patient's/Patient Representative Name (Printed) Witness Name (Printed)

_____ _____
Guardian's Name, if applicable (Printed) Witness Signature

_____ _____
Patient/Guardian Signature Witness Title

_____ _____
Date Date