Circle of Life
Women's Center

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South Ogden, UT 84405
Phone: 801-337-5800
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REQUEST FOR ACCESS TO PATIENT'S HEALTH INFORMATION

As our patient, you are entitled under Federal law to access your Personal Health Information (PHI). Your records are protected and cannot be disclosed without your permission unless otherwise authorized by law. In compliance with state & federal regulations, there may be fees associated with this request. If charged, these fees will be calculated as follows: $21.16 search fee + $0.53 per page for the first 40 pages & $0.32 per page for additional pages + actual cost of postage if mailed. **Please allow up to 7 business days (not including weekends or holidays) to process your request after completing this form**. This request is valid for 30 days only – after which a new request must be completed. This request can be securely emailed to us at medical.records@colwc.com. If you have any questions or concerns regarding your PHI, please contact our Medical Records Department at (801) 337-5800.

Indicate which one of the following methods you wish your records to be provided:

[ ] SECURE EMAIL [ ] MAIL [ ] PICKUP [ ] FAX *(may be limited depending upon amount of records)*

Requested By: [ ] Patient [ ] Healthcare Provider: _____ [ ] Other: _____

Patient Information: Chart No. _____

Name of Patient: _____ Phone No. _____

Full Address: _____ SSN: _____ Date of Birth: _____

Records to Come From:

Name: _____ Phone No. _____

Address: _____ Fax # _____

City, State, Zip: _____ Date Records Required: _____

To be Released to:

Name: _____ Phone No. _____

Address: _____ Fax # _____

City, State, Zip: _____ Date Records Required: _____

Email Address (for secure email delivery): _____

Reason for Request: [ ] Changing Doctors/Practice [ ] Another Doctor Consultation [ ] For Own Use

Requested Records: [ ] Entire Chart [ ] Partial Chart - Date Range: _____ to _____

[ ] Labs: _____ [ ] Other: _____

_____ _____
Patient Signature Patient Name (Print)

_____ _____
Witness Date of Request