PLUMAS COUNTY, CALIFORNIA

REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

Patient Name:_____

I, _____hereby make a request to:

☐ **Inspect** my protected health information;

☐ Receive a **Copy** of my protected health information; or

☐ **Inspect** and receive a **Copy** of my protected health information;

in the possession of _____ for the period

___/___/___ to ___/___/____.

I understand that _____ may charge a reasonable, Cost-based fee for the copying, preparing, mailing and other supplies associated with my request for access.

_____ _____
Signature of patient or Personal Representative Personal Representative's Relationship to Patient

_____
Printed Name

_____

_____ _____
Date

_____
Address and Telephone Number

TO BE COMPLETED BY PLUMAS COUNTY

Date of receipt of request:_____

Signature of person receiving request:_____

Printed Name:_____

Title:_____