# PLUMAS COUNTY, CALIFORNIA

## GRANTING REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

Name of Patient:_____

_____, has granted your request to:

☐ **Inspect** your protected health information;

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

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

as set forth in your Request to Access Protected Health Information dated _____.

**Inspection of Protected Health Information, if applicable:**

Please contact _____ at
Name and Ti tle of contact person

_____ to arrange a convenient
Department and telephone number

time for inspection.

**Copy of Protected Health Information, if applicable:**

_____ will mail to you, at the address listed

on your Request to Access Protected Health Information, a copy of your protected health information for the period requested.

Please mail a check in the amount of $_____, made payable to

_____, to cover the cost for the supplies, copying, preparing and mailing associated with your request for access.

_____

By:_____

Title:_____ Date:_____