

**EAST CAROLINA UNIVERSITY  
HEALTH CARE COMPONENTS**

**INDIVIDUAL'S REQUEST FOR PROTECTED HEALTH INFORMATION**

**NOTICE TO PATIENT:** Your request for access to your protected health information **only** is applicable to the information maintained by Student Health Service. If you would like access to your protected health information maintained by any other Health Care Component of East Carolina University, a separate request should be submitted to that area.

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Banner ID#** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Information Dates From:** \_\_\_\_\_ **To:** \_\_\_\_\_

I hereby request access to the following information:

- |  |  |
|--|--|
| <input type="checkbox"/> Entire Medical Record   | <input type="checkbox"/> Lab Reports       |
| <input type="checkbox"/> Pathology Reports   | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Clinic Notes  | <input type="checkbox"/> Dental Records    |
| <input type="checkbox"/> Billing Statements  | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> Request to be contacted to coordinate a time to inspect/review my health information                              |  |
| <input type="checkbox"/> I will pick up copies <input type="checkbox"/> Fax copies to _____ <input type="checkbox"/> Mail to address below |  |

Copies of the information requested should be mailed to (Any address other than what is maintained by us as your permanent address or that you have indicated to us prior for alternative communication will require a specific authorization to send your health information. Please contact us):

**Address:** \_\_\_\_\_  
\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(of Patient or Legal Representative)

Copy sent as requested on (include detail of information): \_\_\_\_\_

Patient contacted to coordinate review (include detail of information): \_\_\_\_\_

**By:** \_\_\_\_\_  
Signature Title/Location Date