MID AMERICA
HEART & LUNG SURGEONS

"Celebrating 25 years of Heart Transplantation"

CARDIOVASCULAR & THORACIC SURGERY
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# HIPAA Privacy Rights Request Form

## PATIENT INFORMATION

_____
Date

_____ _____
Name (Last, first, middle initial) Social Security # or Patient ID

_____ _____ _____ _____
Street address City State ZIP Code

_____ _____ _____
Primary phone number Other phone number E-mail address

**Type of Request**

☐ Access/copy ☐ Amendment ☐ Restriction
☐ Confidential communication ☐ Accounting of disclosures ☐ Complaint

Please describe nature of action requested (type of information requested; nature of amendment, restriction, alternative communication, or complaint, etc.) **in detail**.

*[Note: If this is an alternative communications request, please list alternative location/address for receiving medical information below.]*

_____

_____

_____

Please list [Company Name] staff members that were contacted regarding this matter:

_____ _____ _____ _____
Name Date Name Date

Signature _____ Date _____

**For Administrative Use Only:** Date received _____

Action taken _____

_____ Date _____

Action taken _____

_____ Date _____

Privacy Official signature _____ Date _____