



**Request to Inspect or Copy Protected Health Information
Benefits Office**

Patient Name: _____

Date of Birth: _____ Date of Request: _____

As an employee of the Dougherty County School System, you have a right under federal law to access your personal health information maintained by the Benefits Office. In order to process your request, please complete this form and submit to the Benefits Office.

You have the right to view your health information, receive a copy of the information, or both. Please indicate your request(s) below:

Family Medical Leave Workers' Compensation.

I would like to VIEW my health information. I will schedule an appointment with the Benefits Office to view my information. I understand DCSS may have a staff member sit with me as I review my information.

I would like a COPY of my health information.

Please indicate below how you would like to receive your health information:

I will pick up the requested materials from the Benefits Office.

I would like a copy of the requested materials mailed to the following address:

Street Address: _____

City/State/Zip Code: _____

I understand that the Benefits Office is given ten (10) working days to process my request for access if my information is maintained off-site and that the Benefits Office may extend the deadline by an additional five (5) days if I am notified in writing of the extension. I further understand that my rights are limited to any information in my medical record as defined in section 164.501 of the Code of Federal Regulations. By signing below I acknowledge and agree to the above conditions.

Signature of Employee or Legal Representative

Date

If signed by legal representative, relationship to patient: _____

To Be Completed By The Benefits Office

Records sent on _____

Sent notice of extension on _____

Request denied on _____

Reason _____