

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 Title 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: _____