# CATHOLIC SOCIAL MINISTRIES, INC.

## INDIVIDUAL REQUEST FOR PROTECTED HEALTH INFORMATION

This form constitutes an individual's request for protected health information (PHI) held by Catholic Social Ministries, Inc. To obtain you PHI this form must be filled out in its entirety.

Name: (First/Middle/Last) _____
Address: (Street/City/State/Zip Code) _____
Date of Birth:_____ Social Security Number: _____
Date of Request: _____

I REQUEST CATHOLIC SOCIAL MINISTRIES TO PROVIDE ME ACCESS TO THE FOLLOWING PHI ABOUT ME:

[] Mental Health Records
[] Billing Records
[] Other _____

I WOULD LIKE TO OBTAIN THE REQUESTED PHI IN THE FOLLOWING FORMAT:

[] Hard copy sent to the following address: _____
_____

[] Other: _____

[] On-site inspection

I UNDERSTAND THAT CATHOLIC SOCIAL MINISTRIES, INC. MAY CHARGE A RESONABLE FEE FOR THE COSTS OF COPYING, MAILING OR OTHER SUPPLIES ASSOCIATED WITH MY REQUEST.

_____ _____
Signature of Individual Date

IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE

_____ _____
Signature of Personal Representative Date

_____
Legal Authority of the Personal Representative