Children's of Alabama

CHILDREN'S OF ALABAMA
REQUEST TO REVIEW AND/OR COPY PROTECTED HEALTH INFORMATION

Patient Information

Patient Name: (Please print)		Request Date:	
Street Address:		Birth Date:	
City/State/Zip:		Date of Service:	

Type of Request (please check as applicable)

☐ Review (Access, Inspect)	I wish to review (access, inspect) the patient's medical records for my personal inspection. If I have any medical questions during my review, I will ask the patient's healthcare provider.
☐ Copy	I authorize Children's of Alabama to make copies of the patient's medical records. I agree to be responsible for reasonable copying fees.

Signature of Parent/Legal Guardian/Patient

I represent that I am the parent/legal guardian/patient and I have the authority to make this request.

Parent/Legal Guardian Print Name:_____

Parent/Legal Guardian Signature:_____Date:_____

Patient Signature if 19 or older:_____Date:_____

Witness Signature:_____Date:_____

** RETURN FORM TO THE COA PRIVACY OFFICER**

Mailing Address: COA Privacy Officer, Children's of Alabama, 1600 7th Avenue South, Birmingham, AL 35233
Fax: (205) 638-2468
Email: HIPAA@ChildrensAL.org
Phone for Questions: (205) 638-5959