Access Request Form

Purpose: This form is used to request, inspect, and/or obtain copies of an individual's protected health information or records in our designated record sets or the designated record sets of our business associates.

SECTION A: Individual whose records are requested

Name:	
Date Of Birth:	
Street Address:	
City, State, ZIP:	
Phone Number:	

SECTION B: To the Requestor – Please read and complete the information requested:

You have the right to inspect and obtain a copy of your protected health information in designated record sets we or our business associates maintain. You are not, however, entitled to inspect or obtain a copy of any psychotherapy notes we may have, any information we may have compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding, any information not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a), and certain other records. To request access to records, please complete the following:

Please specify the records you wish to inspect or obtain copies of:

	APP Visit Notes
	Lab Results
	Records Requested from Other Practices
	All

Time Period Requested From: ____/____/____ To: _____/____/____

Please list the name and address of each person, including yourself or your personal representative, for whom you want us to provide access.

Name:	
Street Address:	
City, State, Zip:	

Name:	
Street Address:	
City, State, Zip:	

Please sign and date:

Signature:	
Date:	

If this request is by a personal representative on behalf of the individual, please complete the following:

Personal Representative's Name:	
Relationship:	

Please complete this form and email, fax, or mail to:

Aspire Healthcare

Attn: Medical Records

22 Century Boulevard

Suite 300

Nashville, TN 37214

Fax : 855-611-1917

Email : Enrollment@aspirehealthcare.com