OFFICE OF
HIPAA
COMPLIANCE
CENTRAL MICHIGAN UNIVERSITY

Request to Access or Receive a Copy of Protected Health Information

I understand that I have the right to inspect or receive a copy of my protected health information. I understand that there may be a fee for copies and mailings and that I will be informed of the fee in advance. I understand that my request to access my records may be subject to some legal limitations and/or limitations established by a licensed healthcare professional to assure my health and safety and the safety of others. I also understand that CMU will respond to this request in less than 30 days unless I receive notification in writing that it will take longer to fulfill my request.

Name:_____ Birthdate (MM/DD/YYYY):_____/_____/_____

Street Address:_____ Phone Number:_____

City, State, Zip Code:_____ Date:_____

1. ☐I wish to inspect the records identified below during regular business hours at CMU.

2. ☐I would like a copy of the records identified below.

   ☐Copy to be mailed to (name, address, telephone number).

   Name:_____
   Address:_____
   Phone Number:_____

   ☐Copy to be picked up at time and place designated by CMU.

3. Identify the items from the records you wish to review or receive.

_____

_____

(Please use additional pages if necessary.)

Time Period if Known: From_____ To _____

_____ _____
Client/Patient/Employee Signature Date

_____
Guardian Signature, if appropriate

_____
Relationship to Client

Revised 10/31/25