



healthcurrent

## Health Information Request Form

**Please complete and return this form to your healthcare provider who will return this form to Health Current.**

Patients have the right to request a copy of their health information that is available through Health Current, Arizona’s health information exchange (HIE). Patients also have a right to request a list of the persons who have accessed their health information through the HIE in the last three years.

If you want to request any of this information, please complete and return this form to your healthcare provider. You will receive a response to the request within 30 days. Please note, Health Current may only send data to an address within the United States of America or its territories. If you are filling out this form for another person, the references to “I” and “my” in this form refer to that other person.

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**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Please check all boxes that apply:**

- I request a copy of all of my health information that is available through Health Current.
- I request a list of all persons who have viewed my health information through Health Current in the past three years. I understand that this list will not include persons who viewed my health information in other ways, such as through a healthcare provider’s electronic health record.

**Signature of Patient or Patient’s Parent/Guardian/Health Care Decision Maker:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If signed by a person other than the patient, please indicate your authority to sign for the patient (check one):

- Spouse     Parent/Guardian     Caregiver with authority to make healthcare decisions

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**Provider Office Only:** This section must be completed before sending via secure fax to Health Current.

Organization/Provider: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Phone: \_\_\_\_\_