1718 N Sterling Avenue
Peoria, IL 61604-3831
Phone: (309) 494-6203 or (855) 268-2455 (855-AMT-BILL)
Fax: 309-494-6537
Email: CustomerService@amtci.org

PATIENT REQUEST FOR MEDICAL RECORDS

Patient Name: ____ Date: _____________________________

Address: ____

City: ______________________________ State: ____________________ Zip Code: _________________

Social Security Number: _____________________________ Date of Service: ________________________

Patient Rights: As a patient, you have the right to access, copy or inspect your protected Health Information, or PHI, in accordance with federal law. You may also have the right to request an amendment to your PHI, or request that we restrict the use and disclosure of it.

To better allow us to process your request, please indicate the type of request you are making on this form: (check all that apply)

___________ Access to simply review my health information

___________ Access to obtain copies of my health information

___________ Access to review and potentially request amendment of my health information

___________Access to review and potentially request an accounting of how my PHI has been used and disclosed to others.

__________ Access to review and potentially request restrictions on the use and disclosure of my health information.

Signature: ____ Request Date: _________________________