Marshall Medical Centers
Many Reasons. One Choice.

ACCESS AUDIT REQUEST FOR PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ **DATE:**_____

DATE OF BIRTH: _____**PHONE:** _____

ADDRESS: _____

I hereby request that Marshall Medical Center conduct an access audit of my protected health information on the CPSI electronic medical record system.

The time period for performance of this audit is:
FROM (date): _____ TO (date): _____

The reason for this request is:

_____

_____

_____

If a privacy violation is suspected, please specify the violation suspected, where the violation occurred, and the individual involved.

_____

_____

_____

Access audits will be performed for specific, not generalized, purposes, i.e. specific individual accessing your protected health information. Following audit performance and review, a letter will be mailed to you regarding the access audit findings.

Signed: _____
(Patient) (Date)

_____
or (Patient Representative) (Relationship to Patient) (Date)

Printed: _____
(Patient Representative) (Relationship to Patient) (Date)

Return to: Health Information Management, Marshall Medical Centers,
227 Brittany Road, Guntersville, AL 35976 or fax to 256-894-6636

Effective 5/2014