THRIVE
BODYWORKS LLC

Request to Inspect or Copy Protected Health Information (PHI)

Client Information:
Name: _____
Date of Birth: _____

I request to inspect or obtain copies of the following health records (check all that apply):
☐ Medical History
☐ Treatment Records
☐ Billing Information
☐ Other:
_____
_____

Timeframe (if applicable):
From: _____ To: _____

Delivery Preference:
☐ Paper Copies
☐ Electronic Copies (e.g., PDF via secure email, USB drive)
☐ In-Person Inspection

**Fees may apply for copies, in accordance with state law.*

Signature of Client/Legal Representative:
Signature: _____
Date: _____

Legal Representative Information (if applicable):
Name: _____
Relationship to Client: _____

Acknowledgment by Covered Entity:
☐ Request Approved
☐ Request Denied
(Reason:
_____
_____)

**Your request will be processed within 30 days. If an extension is needed, you will be notified in writing.*

Covered Entity Representative
Name: _____
Signature: _____
Date: _____