MIAMI HEALTH SERVICES

Managed by: TriHealth

Patient Name: _____ Date of Birth: _____

I authorize TriHealth to call me at _____ with my COVID-19 test results.

If I do not answer, I authorize the test results to be left on my voicemail. I also authorize my results to

Be emailed to me at the following email address _____.

_____ _____

Patient Signature Date

This is in line with our Authorized Release of Medical Information and Access Requests policy.

II. **Right of Access.** A patient has to inspect and obtain a copy of his/her **PHI** in the form and format requested by the patient. TriHealth shall grant a patient the right to access or obtain a copy of his/her **Medical Information** when presented with a valid access request as long as the information is retained by TriHealth, or by a business associate on TriHealth's behalf. If it is not readily producible, it may be produced in a readable hard copy form or other form and format agreed to by TriHealth.

A. The patient must submit, in writing, his/her request to inspect or receive a copy of his/her **PHI** to HIM. The request should include:

1. Identifying information about the patient to ensure access is provisioned correctly;
2. The form and format that the patient wishes to receive a copy of the records; and
3. Identify where the **PHI** should be sent: to the patient, a designated third party or entity.