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[www.henrycohd.org](http://www.henrycohd.org)

## Request for Access to Protected Health Information/ Request for Communication by Alternate Means

I, \_\_\_\_\_, hereby request a copy of my health information from Henry County General Health District for the period of \_\_\_\_\_. I understand that I may access my health information through any of the following methods.

Please check the desired method:

I prefer to inspect and/or copy the requested information in person and will arrange for a mutually convenient time to come to Henry County Health Department by calling the health department number as listed above. I understand that I will be responsible for paying a per page copying fee of \$0.25.

I prefer to have the requested information copied and mailed to me at the following address: \_\_\_\_\_. I understand that I will be responsible for paying a per page copying fee of \$0.25.

I prefer to have the requested information emailed to me at the following email address: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature (Guardian or Health Care Power of Attorney)

\_\_\_\_\_  
Date

Henry County Health Department Response to request for PHI and communication

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
HCHD Privacy Officer Signature

\_\_\_\_\_  
Date

HCHD Original: 4/03, 11/2017, 9/2018