



REQUEST FOR ACCESS TO HEALTH INFORMATION

You have the right to inspect and/or copy your medical record maintained by this office, unless law prohibits access to the information or denial is made in the exercise of professional judgment. In the case of denial of access, you will be notified in writing and provided with information on how to obtain a review of that denial.

Patient Name

Date

Social Security #

Medical Record Number

Date of Birth

Phone Number

Address

Dates of Service

Description of Information to Access _____

Format:

- I would like a copy of my entire record. I understand fees may apply and agree to pay such cost on receipt.
- I would like to review my records on site. I understand I will be contacted by the records department to arrange a date and time.
- I would like a summary of my requested health information rather than the actual record. I will be contacted by the custodian of records with an estimate of the cost of a summary. I am not obligated to pay for a summary unless I agree to the cost. If I do not agree to the cost, I may withdraw my request for a summary and request the actual records. I agree to pay such cost on receipt of the summary.

Signature of Patient

Date

You will receive your requested records within 30 days. If the records are located off site it may take up to 60 days and you will be notified that such delay will occur.

Signature of patient/patient representative

Date

Description of patient representative authority

Date