



### ACCESS REQUEST

Purpose: This form is used for an individual’s request to inspect and/or obtain copies of the individual’s protected health information or records in our designated record sets or the designated record sets of our business associates.

**SECTION A: Individual requesting access. (\* represent required information)**

\*Name: \_\_\_\_\_

\*Address: \_\_\_\_\_

\*Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient Number: \_\_\_\_\_ \*Social Security Number: \_\_\_\_\_

**SECTION B: To the Individual—Please read the following and complete the information requested.**

You have the right to inspect and obtain a copy of your protected health information in designated record sets we or our business associates maintain. You are not, however, entitled to inspect or obtain a copy of any psychotherapy notes we may have, any information we may have compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding, any information not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a), and certain other records. To exercise your right of access, please complete this Section B.

\*Please specify the records you wish to inspect or obtain copies of: \_\_\_\_\_

\_\_\_\_\_

Do you wish to:      Inspect these records? \_\_\_\_\_                      Obtain copies of these records? \_\_\_\_\_

**Fees for Copying Medical Charts**

*Due to the high cost of maintaining the privacy and security of medical records, we charge for copies of Medical Records. Current rates are posted in our offices or can be obtained by contacting our offices.*

In what form or format (e.g., paper or electronic) would you like us to make the records available to you?

\_\_\_\_\_

\*Do you want us to mail the copies? \_\_\_\_\_ We will charge you for the postage.

\*Please list the name and address of each person, including yourself or your personal representative, for whom you want us to make copies. If you want us to provide access to or copies of your records to any person other than you or your personal representative, you must provide us with a signed authorization. We can supply you with the appropriate authorization form.

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

**SIGNATURE (\* represent required information)**

\* \_\_\_\_\_ \*Date: \_\_\_\_\_

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative’s Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS REQUEST.**