



## PATIENT ACCESS TO THE MEDICAL RECORD REQUEST FORM

I, \_\_\_\_\_, request access to my medical records for my personal inspection or by \_\_\_\_\_, my personal representative.

(Please request date and time requested for record access)

Date \_\_\_\_\_ Time \_\_\_\_\_

### OR

I, \_\_\_\_\_, request Acute Allergy Asthma and Immunology of Atherton make copies of my medical records for my personal inspection. I understand that these records contain protected health information (PHI). I agree to be responsible for the cost of copying these records, including copying fees, labor, supplies, and postage (if applicable). The charge for this will be \$.25 per page\* and I will be charged a minimum of \$5.00. I agree to pay for this prior to the service being rendered.

Patient Signature \_\_\_\_\_

Patient Printed Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Date of request \_\_\_\_\_

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### **Practice Response to Request** (Must be within 60 days of receipt of request.)

\_\_\_\_\_ Grants all or part of your request \_\_\_\_\_

\_\_\_\_\_ Denies all or part of your request \_\_\_\_\_

For the following reason: (Circle all that apply)

Not part of your designated record set; contains psychotherapy notes; information was compiled for civil, criminal or administrative actions; subject to CLIA; regards inmate at correctional institution; was created during research; is subject to Federal privacy act; was not created by this practice.

### **Patient may not appeal if denial is for any of the above reasons**

\_\_\_\_\_ Denied at the discretion of the practice as the information may be harmful to the patient or a third party

\_\_\_\_\_ Requests a 30-day extension to respond due to \_\_\_\_\_

*\*Many states have laws that govern how much you may charge for the copying of medical records. Please consult your state laws prior to assessing any fees for copying records.*