INSPECT/OBTAIN COPY OF MEDICAL RECORDS REQUEST FORM

Patient Name (First/MI/Last)**:** _____

Date of Birth (mm/dd/yyyy)**:** _____

I request that my medical records be:

☐ Made available to me for my inspection in person via appointment.

☐ Mailed/Emailed (circle one) to **me** in ____ Paper Copy or ___CD or ___Flash Drive to the following address:

_____

Mailed/Emailed (circle one) to the following **person/entity** at the following address in ____ Paper Copy or ___CD or ___Flash Drive:

_____

Name

_____

Address

_____

Email Address

The medical records I wish to inspect/obtain a copy of include: (check all that apply):

☐ **Entire** Medical Record

☐ **All** records created between the dates of _____ and _____

☐ **Medical records related only** to the following diagnosis/services provided/products purchased:

_____

_____

Electronic Format: Medical Records provided on CD or Flash Drive will be in PDF format unless otherwise requested and ***will not be encrypted or password protected in anyway***. To request an alternative format, please describe the format type you prefer below:

_____

Please Note: Health Services, LLC may not be able to provide you your medical information in the electronic format of your choosing. If we cannot meet your request we will contact you to discuss a mutually agreeable alternative format.

I understand that:

- Health Services, LLC may decline this request under limited circumstances permitted by federal or state regulations governing the protection of personally identifiable health information. Except for denials permitted by federal or state law I further understand that I have the right to have a denial reviewed by a licensed health care provider selected by Health Services, LLC that was not involved in the initial decision.
- Health Services, LLC has 30 days from the receipt of my request to notify me of their decision to approve or decline this request or 60 days if additional time is required to retrieve my information, due to off-site storage for example.
- I may be charged a reasonable cost-based fee for a copy of my medical records, as allowed by HIPAA and applicable state law, and I agree to pay such fee.
- Once my health information is disclosed as requested, it may no longer be protected by federal and/or state privacy laws, and could be re-disclosed by the person(s) receiving it.

_____ _____

Patient Signature Date (required)

If you are **NOT** the patient but are signing on behalf of the patient, please complete the following section. Please be prepared to provide proof of your authority to act on the patient's behalf as indicated above, with the exception of "parent".

I am the above referenced patient's:

- ☐ Parent w/ parental rights
- ☐ Registered kinship care relative
- ☐ Legally appointed healthcare agent
- ☐ Surrogate Decision Maker
- ☐ Power of Attorney with Right to See Medical Records
- ☐ Court appointed guardian
- ☐ Medical power of attorney
- ☐ Court Appointed Personal Representative of Deceased

Representative Signature _____ Date (required) _____

Representative Printed Name _____ Phone _____

Address _____

Submit this completed form to: [submission instructions]

Internal Use Only

Date Request Recv'd: _____

Decision: ___ Accepted ___Declined Decision Date: _____

If Declined, reason: _____

_____

_____

Decision Communicated to Patient: _____ (Date)

Action Taken:

Inspection Appointment Scheduled: __ Yes __ No __ N/A Appointment Date: _____

File Requested from Off-Site Storage: __ Yes __ No __ N/A Request Date: _____

Requested Information Copied To: __ Paper __ CD __ Flash Drive __Other: _____

Medical Records Sent Via: __ Mail __Email (Encrypted) __Email (Unencrypted)* __Patient/Rep Picked-Up

Date Sent: _____

*Reason for Unencrypted Email: _____