Patient Records Access Form

Patient Name: _____ Date of Birth: _____
(Please print)

Account No. _____
(Office Use)

I would like to:

☐ inspect ☐ obtain a copy of ☐ both inspect and obtain a copy of my protected health information records at this practice.

Inspection

I would like to visually inspect the following:

☐ my complete record at this practice.

☐ my record at this practice for time period _____ through _____.

☐ a specific section of my record (please describe): _____

_____

☐ I would like to inspect my records on the following date and time: _____

Obtaining a Copy

I would like to obtain a copy of the following:

☐ my complete record at this practice.

☐ my record at this practice for time period _____ through _____.

☐ a specific section of my record (please describe): _____

_____

I request the record in the form of:

☐ readable hard copy.

☐ a summary in lieu of receiving the complete record.

Delivery

☐ I would like to pick up the copy of my records at:

☐ Princeton Avenue office

☐ Neck & Back Institute office

☐ Forsgate office

Please call when ready (_____) _____
area code phone number

☐ Please mail the copy of my records to: _____

_____

Your agreement will be requested in advance for any copying or mailing fees that the practice incurs to fulfill your request. This practice has the right to deny access, in which or in part, to protected health information if the records are psychiatric notes, are a matter of national security or public health policy, are part of legal proceedings, were provided by a nonprovider under promise of confidentiality concerning their identity, or could place in danger your life or the lives of others.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____