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|---|---|-------------|
| <b>Patient Name:</b><br><b>Address:</b><br><b>Phone Number:</b> | <b>Date of Birth:</b><br><b>Fax Number:</b> | <b>SSN:</b> |
|---|---|-------------|

**Access Request to Copy/Inspect**

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|--|--|--|---|
| <b>1. Information may be disclosed to:</b>   | Name:<br>Address:<br>Phone: _____ Fax: _____   |  |   |
| <b>2. Information may be disclosed by:</b>   | Name/Entity:<br>Address:   |  |   |
| <b>3. Information to be disclosed. Check the appropriate boxes in 3(A) to authorize release of the complete medical record or itemized records.</b><br><br><b>DATE(S) OF SERVICE:</b> _____  | 3(A). State type(s) of information that may be disclosed.<br><b>___ My complete medical record(s), except for 3.1(B), or:</b>  |  |   |
|  | <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; border-right: 1px solid black;"> <input type="checkbox"/> Discharge Summary<br/> <input type="checkbox"/> Emergency Room<br/> <input type="checkbox"/> History &amp; Physical<br/> <input type="checkbox"/> Consultation Reports<br/> <input type="checkbox"/> Operative Reports<br/> <input type="checkbox"/> Rehab Services<br/>           Type: _____<br/> <input type="checkbox"/> Laboratory Results         </td> <td style="width:33%; border-right: 1px solid black;"> <input type="checkbox"/> Nursing Notes<br/> <input type="checkbox"/> Medication Records<br/> <input type="checkbox"/> Physicians Orders<br/> <input type="checkbox"/> Physician Progress Notes<br/> <input type="checkbox"/> Billing records<br/> <input type="checkbox"/> Photographs<br/> <input type="checkbox"/> Other (please specify)         </td> <td style="width:33%;"> <input type="checkbox"/> Radiology Reports<br/><br/> <input type="checkbox"/> Copy of Radiology exam films<br/><br/> <input type="checkbox"/> Original Radiology exam films*         </td> </tr> </table> | <input type="checkbox"/> Discharge Summary<br><input type="checkbox"/> Emergency Room<br><input type="checkbox"/> History & Physical<br><input type="checkbox"/> Consultation Reports<br><input type="checkbox"/> Operative Reports<br><input type="checkbox"/> Rehab Services<br>Type: _____<br><input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Nursing Notes<br><input type="checkbox"/> Medication Records<br><input type="checkbox"/> Physicians Orders<br><input type="checkbox"/> Physician Progress Notes<br><input type="checkbox"/> Billing records<br><input type="checkbox"/> Photographs<br><input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Discharge Summary<br><input type="checkbox"/> Emergency Room<br><input type="checkbox"/> History & Physical<br><input type="checkbox"/> Consultation Reports<br><input type="checkbox"/> Operative Reports<br><input type="checkbox"/> Rehab Services<br>Type: _____<br><input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Nursing Notes<br><input type="checkbox"/> Medication Records<br><input type="checkbox"/> Physicians Orders<br><input type="checkbox"/> Physician Progress Notes<br><input type="checkbox"/> Billing records<br><input type="checkbox"/> Photographs<br><input type="checkbox"/> Other (please specify)  | <input type="checkbox"/> Radiology Reports<br><br><input type="checkbox"/> Copy of Radiology exam films<br><br><input type="checkbox"/> Original Radiology exam films*   |   |
| <b>3.1. Initial and check box 3.1(B) to indicate whether you consent to the release of the health records described in box 3.1(B).</b>   | 3.1(B). ___ (initials) <b>I DO</b> [ ] or <b>I DO NOT</b> [ ] consent to release of information relating to psychiatric or psychological testing or treatment, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV(AIDS) testing and/or results, or such disclosure shall be limited to the following specific types of information:<br><b>*** NOTE: If this section is not completed, then records of this type, if they exist for this patient, will not be released. ***</b>  |  |   |
| <b>4. Purpose for disclosure:</b>  | <input type="checkbox"/> Further Medical Care <input type="checkbox"/> Insurance Eligibility/Benefits<br><input type="checkbox"/> Personal <input type="checkbox"/> Legal Investigation or Action<br><input type="checkbox"/> Changing Physicians <input type="checkbox"/> Other: _____  |  |   |

5. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol abuse. This information is being provided to you from records whose confidentiality may be protected by State and/or Federal law.

6. I understand that your facility may receive compensation for medical record copying in accordance with State law.


7. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988, (42 U.S.C. section 263 (a)), and certain other records.

8. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described in #7 above.

9. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization.

10. I understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. **This authorization expires within 90 days, unless otherwise specified.**

|  |                      |                                   |                      |
|--|----------------------|-----------------------------------|----------------------|
| _____<br><b>Signature of Patient/Representative</b>  | _____<br><b>Date</b> | _____<br><b>Witness Signature</b> | _____<br><b>Date</b> |
| (If signed by person other than the patient, identify relationship and authority to do so below.)  |                      |                                   |                      |
| Patient is: <input type="checkbox"/> Minor <input type="checkbox"/> Incompetent <input type="checkbox"/> Disabled <input type="checkbox"/> Deceased        |                      |                                   |                      |
| Legal Authority: <input type="checkbox"/> Custodial Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Executor of Estate of Deceased |                      |                                   |                      |
| <input type="checkbox"/> Power of Attorney for Health Care <input type="checkbox"/> Authorized Legal Personal Representative                               |                      |                                   |                      |

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|--|------------------------|
|  <p style="text-align: center;"><b>AUTHORIZATION FOR RELEASE, USE,<br/>AND DISCLOSURE OF PROTECTED<br/>HEALTH INFORMATION</b></p> | PATIENT IDENTIFICATION |
|--|------------------------|