Hollingshead Eye Center, P.C.℠

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REQUEST FOR ACCESS TO MEDICAL INFORMATION

Our Notice of Privacy Practices provides information about our use of a patient's protected health information. The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect, and copy protected health care information used to make decisions about them. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Practice will only include information used to make decisions about the patient. The practice may limit access to information generated only by this practice. Under some circumstances, such as increased risk of harm or injury, the practice may withhold the requested information. The Privacy Office of this practice will evaluate this request and notify the patient of our decision within fifteen (15) days of the request. If the request is approved, the practice will provide the information within thirty (30) days, or with sixty (60) days if such an extension is necessary. Reasonable cost will be charged for the request. Costs will be submitted to the patient upon approval of the request.

Patient Name: _____ DOB: _____

For the health care information requested; please provide dates, diagnosis, treatment, or any other indications of the specific information you desire:

_____

From: _____

_____

_____

- ❑ I will pick up the copies
- ❑ Fax: _____
- ❑ Email: _____
- ❑ Mail to**:** _____

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This request signed by: _____ Date: _____
Patient or Representative Signature

Relationship to Patient (if other than patient): _____

Records Prepared by: _____ Date: _____

Records Released by: _____ Date: _____