



REQUEST FOR ACCESS TO PATIENT HEALTH INFORMATION

Patient Name: _____

Date Of Birth: _____

SSN: _____

- Purpose Of Request: [] Second Opinion [] Continuation Of My Treatment
[] For My Attorney [] Transfer Of My Care To Another Provider
[] Other _____

As a patient of Alliance Orthopaedics & Sports Medicine, P.C., you are entitled to access your personal protected health information. You have the right to view your information, obtain a copy of the information, or both. Please indicate below whether you wish to view the information only, obtain a copy, or both.

- [] I would like to view my medical record. I understand that a staff member of Alliance Orthopaedics will contact me to schedule an appointment to sit down with me as I review my health information.
[] I would like a copy of my entire medical record. I understand that I am financially responsible for the following fees associated with my request:
\$20.00 for administrative costs (copying charges, including cost of supplies, labor, & postage)
I understand that payment of this fee is requested in advance.
[] I would like a copy of my report. Select one: [] MRI/CT [] NCS [] FCE [] Operative Report
[] I would like Alliance Orthopaedics to provide me a written summary of the information. I understand that I am financially responsible for the fee for the summary, and I will be required to pay the fee in advance before my request is processed.

Please indicate your preferred method of delivery of your health information.

- [] I will return to Alliance Orthopaedics and pick up the copy when it is ready. Please call: ()
[] I would like Alliance Orthopaedics to send the copy via U.S. mail to the following address:
[] I would like Alliance Orthopaedics to send the copy via facsimile to the following number: ()

I understand that Alliance Orthopaedics is given thirty (30) days to process my request for access if my information is maintained on-site, sixty (60) days if the information is maintained off-site, and that Alliance Orthopaedics may extend the deadline by an additional thirty days if I am notified in writing of the extension.

By signing below, I acknowledge and agree to the above conditions.

Signature of Patient Or Legal Guardian

Date

Print Name Of Patient or Legal Guardia