PATIENT REQUEST TO ACCESS PERSONAL HEALTH INFORMATION

Send to: Dr. Mendy Maccabee
514 State Street
Hood River, OR 97031

phone: (541) 436-3880
fax: (541) 436-3881
e-mail: office@mendymaccabeeent.com

Requested from:

_____
Name & Street Address, City, State, Zip Code

The following is to be completed by patient or personal representative
Date: ____/_____/ 20___

Patient: _____
Date of Birth: ____/____/____

Address: _____

_____

Email Address: _____

What are the date(s) of treatment for which you would like records?
__ Treatment provided between ____/____/____ to ____/____/____.
__ Treatment provided at anytime.
Other:_____

What type of records would you like to obtain?

__ Medical records (please specify)
__ History and physical, exam notes, progress notes, etc.
__Consultation reports.
__ Operative, surgical, and procedure reports
__ Laboratory, pathology, and other test results.
__Diagnostic, images, films, or other recordings (e.g., x-rays, MRI scans, CT scans, photos, etc.)

(Note: images, films, photos, and other recordings are subject to higher charges)
__ Other: _____
__Billing and payment records

__Summary of records identified above. (Note: we may charge you for the cost of preparing the summary)
__Other: _____

How would you like to receive the records?
__Patient will review records at the Practice.
__ Patient will pick up copies of records from the Practice.
__Patient will review records electronically in their Patient Portal **(Note: there is no charge for this option)**
__Mail the records to the Patient address above
__Send electronic copy in secure message to the following email address:

_____
FORMCHECKBOX Other:
_____

I certify that I am the patient identified above or that I am the person with legal authority to make health care decisions for the patient identified above.

Name: _____
Date: ____/____/____

Signature: _____
Telephone: _____

If personal representative, describe relationship to patient or authority:
_____
_____
_____

Medical Record No.: _____

RESPONSE TO PATIENT REQUEST TO ACCESS PERSONAL HEALTH INFORMATION

Patient Name: _____

_____

_____

To be completed by practice personnel.

The Practice must normally respond to a patient's request to access records within 30 days. If the requested records are maintained off-site, Practice may respond within 60 days. Specific requirements for responding are found in 45 CFR 164.524. Practice personnel who respond to such requests should be familiar with the requirements of the regulation and Practice's policy for responding to requests.

Date record request received by Practice: ____/____/____
Date Practice notified patient of response: ____/____/____
Date records provided: ____/____/____

Response to the request.

FORMCHECKBOX **Request accepted**; records provided by following means:
FORMCHECKBOX Patient reviewed records at Practice.
FORMCHECKBOX Patient picked up copies of records at Practice.
FORMCHECKBOX Patient will review records electronically in their Patient Portal
FORMCHECKBOX Records sent to patient or personal representative address indicated on request form
FORMCHECKBOX Records sent electronically to the e-mail address indicated by patient.
FORMCHECKBOX Other:
_____

FORMCHECKBOX **Request denied** in whole or in part for following reason:
FORMCHECKBOX Psychotherapy notes withheld.
FORMCHECKBOX Requested records were not in patient's designated record set, i.e., they were outside Patient's medical or account records.
FORMCHECKBOX Information in records was obtained from someone other than the patient under a promise of confidentiality.
FORMCHECKBOX Providing records is reasonably likely to cause substantial harm to the patient or another person. If relying on this basis, Practice must give patient the opportunity to have the decision reviewed by another provider identified by Practice. See 45 CFR 164.524(a)(3) and (d)(4).

If the request is denied in whole or in part, Practice must do the following:
FORMCHECKBOX Notify patient in writing of the basis of the denial, the process for submitting a complaint to the Practice if the patient disagrees with the decision, and if applicable, the right to have decision reviewed by independent provider.
FORMCHECKBOX Provide other records that are not subject to the denial to the extent requested.

FORMCHECKBOX **Practice does not maintain the requested records.** If Practice knows where the records are, inform the patient where to direct the request.

Practice representative responsible for responding to request:

Name: _____

Title: _____

Maintain a copy of this request in the patient's medical record.

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PAGE 2