"Helping You to a Healthy Heart"

Patient's Request for Access to PHI

(585) 442-5320

1. Request. I request the following (check all that apply):

____ that the Practice allow me to inspect the protected health information relating to me that is described below ("PHI"); and

____ that the Practice provide me with a copy of the PHI.

2. Form of Access. I understand that the Practice will provide me with access to the PHI in readable hard copy form unless I request some other form or format. The Practice will comply with my request for an alternate form or format only if the Practice can readily produce the PHI in that form or format. I hereby request an alternate form or format described as follows: ____

3. Summary/Explanation. If I agree, the Practice may provide me with a summary or explanation of the PHI in lieu of providing access to the PHI. However, I must also agree to pay the Practice a fee to create such a summary or explanation. I do not (do) request a summary or explanation of my PHI.

4. Fees. If I request a copy of my PHI, I understand that the Practice may charge me a reasonable cost-based fee to respond to this Request, but the charge for paper copies shall not exceed $.75 per page. The Practice may also charge me for postage if I request that the Practice mail the PHI to me. I do (do not) request that the Practice mail the PHI to me.

5. Time to Respond. I understand that the Practice has 10 days after receipt of this Request to provide me with an opportunity to inspect the PHI, and a reasonable amount of time to provide me with a copy of the PHI, which shall not be less than 10 nor more than 60 days.

6. Denial of Access. I understand that there are reasons why the Practice may deny, in whole or in part, my request to inspect and/or copy the PHI. I further understand that the Practice will provide me with written notice of any such denial, the reason for the denial, and in what circumstances and how I may request a review of that denial.

____________________________________ ______________________________________

Name of Individual (Printed) Signature of Individual

______________________________________ ______________________________________

Signature of Personal Representative Relationship (e.g., Attorney-In-Fact, Guardian, Parent if a minor)

Phone Number:_______________________

Address (for purposes of mailing a Response to this Request): ______________________________

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Date Signed _____/_____/________

DESCRIPTION OF PHI and the period of time covered (for example, PHI for care provided from January 1, 2001 to June 30, 2002).____

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