

Request To Access Medical Record

I, (name) _____ SSN ____ - ____ - _____, as a patient of _____ do request access to / a copy of my medical record(s) as specified below:

NOTE: A fee will be charged for copies of contents or summary statements of the medical record.

If a copy is requested, please indicate whether the copy is to be:

___ sent to the patient's residence;

___ retained in our offices to be picked up.

Date of Request _____ (Cannot Be More Than 60 Days Prior to Submission)

Signature of the Patient _____

Signature of Guarantor _____

Sign If Patient Is A Minor

Date received by Site Compliance Contact/Office Manager _____

Date Request granted _____

Date Documentation Released: _____

Prepared by: _____

Date Request Denied: _____

Date response sent patient: _____

Denial Report Prepared by _____

Appeal granted by: _____

Date Documentation Released: _____

Appeal Report by: _____