Request for Access to Medical Record

Customer Information

Date of request_____ Customer Number_____

Name_____ Date of birth _____

Address_____

Send my medical record to this address (if different from above)

_____

Dates requested

- ✍ I want you to **mail** me a copy of my medical records for the **following dates**:
- ✍ I want to **visit your location** to see my medical records for the **following dates**:

  From: _____ To: _____

  This information is (Describe)_____

  _____
- ✍ I want to get a copy of my **complete medical record** by **mail**.

Fees

A reasonable fee will be charged for copying and mailing your records. State law usually decides this fee. I understand that there is a fee to copy my medical records and I want to proceed: ✍ No ✍ Yes

Response time

I understand that I will get the records I have asked for within 30 days or less according to state and federal law unless I am notified in writing that additional days (up to 30 days) are needed, or that my request has been denied.

_____ _____

Signature of customer or legal representative Date

For Pharmacy Use Only

Date request received _____ Date request met _____

Request is for a minor child's records: ✍ No ✍ Yes

If yes, authority to access records determined: ✍ No ✍ Yes

Patient notified of denial to access record in writing on this date _____

Employee processing request _____

Referenced in Pharmacy Operations Manual—HIPAA: Customer Access to Protected Health Information and Customer Authorization for Disclosing Protected Health Information