REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

∗Patient Name: _____ ∗Date of Birth: _____

RE: Medical Records Maintained by PEARL CITY MEDICAL ASSOCIATES, INC.

_____ Request for access to review entire medical record.

_____ Request for access to specific documents (describe): _____
_____

_____ Request for copies of the following:
_____ Complete medical record
_____ Copies of records pertaining to the period from _____ to _____
_____ Copies of specific documents (describe):
_____ Dates: _____
_____ Dates: _____

_____ Request for a summary of services provided to me during the period from:
_____ to _____

Reason for Request: ☐ Legal Purposes ☐ _____

_____ Mail copies to me at this address: _____
_____

_____ Call me at (____) _____ to pick up records

_____ Fax records to me at (____) _____

_____ Send records to me via MyChart, if applicable

_____ I authorize _____ to pickup the copies on my behalf.

I understand that:
- There will be a copying charge of $ .10 per page.
- The cost of preparing a summary will be a minimum of $50.00.
- The law may require denial of access in certain circumstances. I will be notified in writing if access is denied and the reasons for denial.

_____ _____
∗Signature of Patient or Legally Authorized Representative+ ∗Date

_____ _____
∗Printed Name of Patient or Legally Authorized Representative+ ∗Relationship to Patient

∗+Attach documentation/proof of legal authority

∗Items must be completed.

FOR OFFICE USE:
Copies released on: _____ Via: Mail _____ Fax: _____ Pickup: _____
Access not permitted (indicate reason):_____
Letter sent to patient on: _____
By: _____