MEDICAL RECORDS REQUEST

Fax completed form to: (702) 731-0741

Submission date: _______________

Purpose: This form is used for an individual's request to inspect and/or obtain copies of the patient's protected health information or records in our designated record sets or the designated record sets of our business associates. Please provide a legible document.

SECTION A: Patient name.

Name: ____

Also known as or previous legal name: ____________________________

Address: ____

Telephone: ____________________________ DOB: ____________________________

Social Security Number: ____________________

DOC Practitioner: ________________________ Last Seen: ____________________________

SECTION B: To the Patient—Please read the following and complete the information requested.

You have the right to inspect and obtain a copy of your protected health information in designated record sets we or our business associates maintain. You are not, however, entitled to inspect or obtain a copy of any psychotherapy notes we may have; any information we may have compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding; any information not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a) and certain other records. To exercise your right of access, please complete this Section B.

Records You Wish to Inspect or Obtain Reproductions:

Paper Records in Chart _______ Images including X-Ray, MRI, CT films, etc. ________

Do you wish to: Inspect these records? _____ Obtain copies of these records? _____

We will charge you $ .60 per page to copy paper records and $15 per film or CD for medical images.

What office address would you like to pick up the records at?

Desert Inn Office _____ Centennial Office _____ Horizon Ridge Office _____

Do you want us to mail the copies? _____ We will charge you for the postage.

Please list the name and address of each person, including yourself or your personal representative, for whom you want us to make and/or mail copies.

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

If you want us to provide access to or copies of your records to any person other than you or your personal representative, you must provide us with a signed authorization. We can supply you with the appropriate authorization form.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE:

____ Date: ____________________

If this request is by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.

(PID: __________________ for internal use only)