Patient Records Request Form

Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule at §164.524© (as amended by the final rule) when an individual requests an electronic copy of their protected health information that is maintained electronically in one or more designated record sets, the covered entity must provide the individual with access to the electronic information in the electronic form and format requested by the individual, if it is readily producible, or, if not, in a readable electronic form and format as agreed to by the covered entity and the individual.

Patient Information (information about person whose records are being requested)

_____

Last Name First Name Middle Initial

Social Security Number _____

Birthdate (mm/dd/yyyy) _____

Daytime Phone _____

Street Address _____

City, State, Zip Code _____

Records Requested

- ❒ Recent labs
- ❒ All labs
- ❒ Complete medical record
- ❒ Other: _____

Delivery Options

- ❒ Paper copy of information via US Mail to address listed above.

  A charge of 50¢ per page plus postage applies to mailed records.
- ❒ Paper copy of information via fax to the following fax number: _____
- ❒ Electronic copy of information via flash drive or CD.

  A charge of $8 applies to CDs. A charge of $10 applies to flash drives.
- ❒ Allow me to pick up a paper copy of my records.
- ❒ Allow me to view my records in person. I understand that I will be contacted to arrange for this.

Right to Request Information

I understand that I have the right to inspect or obtain a copy of my personal health information (PHI) maintained by the Dermatology and Skin Surgery Center of Princeton (DSSC). I understand that DSSC will make every reasonable effort to provide me access to my PHI. DSSC may provide a summary, in lieu of providing access to the PHI requested, or may provide an explanation of the PHI to which access has been provided, if I agree in advance to the summary, and if I agree in advance to the fees imposed for such summary. The fee for copying my PHI includes the costs of supplies and labor for copying or for preparing an explanation, or summary, if agreed, and postage, if applicable.

Right of Denial

I understand that DSSC has the right to deny my request for access to the extent allowed by law, such as:

Psychotherapy Notes

Patient agreed to denial of access while in research project

Information for use in civil, criminal or administrative proceedings

Information obtained from source other than facility under promise of confidentiality and access would identify the source

Request Fulfillment

I understand that, if approved, the requested records:

1) Will be furnished in a form or format that is acceptable to me, if readily reproducible in that form or format; or, if not, in a readable hard copy form;
2) Will be furnished as quickly as possible, but no later than 30 days after the request was submitted, (or 60 days if the information is maintained off-site, or if DSSC notifies me within 30 days that it needs a one-time extension for no more than an additional 30 days);
3) May be furnished by a Business Associate who stores and maintains the requested records.

I understand that I may be charged a reasonable fee for copying the requested records and mailing the records (if requested).

Signature

_____ _____

Signature of Patient or Patient's Personal Representative Date (mm/dd/yyyy)

If signed by a Personal Representative, please complete the information below:

_____ _____

Signature of Personal Representative Relationship to Individual

_____

Personal Representative's Address: City, State, Zip

_____

Personal Representative's Telephone Number with Area Code

_____

Personal Representative's Email Address (if applicable)