Treat MS

Medical Record Access Request

Patient Name_____Today's Date_____

Patient Address _____

City_____State: _____ Zip_____

Last Four Digits of SSN_____Date of Birth _____Phone_____

Medical record number(s) / Account(s)_____

The purpose of this application is to request copies of my medical records as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations.

Location Treated:

Dates of treatment: From _____ To _____

I request copies of the following health records related to my treatment between the above dates.

_____

_____

_____

_____

_____

☐ Check the box if your would like to get a copy of all health records that we have between the above dates.

☐ Check the box if your would like to get a summary of you health records that we have between the above dates.

Please mail the requested records to me at the address below.

Name_____Address_____

Signature below is acknowledgment that I understand I may be charged a reasonable fee for copying the records, but will not be charged for time spent locating the records. [If the records are mailed, I may also be charged for postage.]*

Patient's Legal Representative's Signature_____Date _____

Legal Representative's Printed Name_____Relationship to Patient _____

Medical Record Access Request *(Continued)*

1. *Under HIPAA you can be charged a reasonable fee for copying records. You may also be charged for postage if you ask that records be mailed to you. HIPAA allows 30 days for a provider to respond to your request for records, with one 30-day extension for good reason.