NH EYE ASSOCIATES

REQUEST FOR ACCESS TO MEDICAL INFORMATION

Our Notice of Privacy Practices provides information about our use of a patient's protected health information. The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect, and copy protected health care information used to make decisions about them.

The practice will only include information used to make decisions about the patient. The practice may limit access to information generated only by this practice. Under some circumstances, such as increased risk of harm or injury, the practice may withhold the requested information. The privacy officer of this practice will evaluate this request and notify the patient of our decision within fifteen (15) days of this request. If the request is approved, the practice will provide the information within thirty (30) days, or within (60) days if such an extension is necessary. Reasonable costs will be charged for the request. Costs will be submitted to the patient upon approval of the request.

The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Name: _____ DOB: _____

Health care information requested. Please provide dates, diagnosis, treatment or any other indications of the specific information you desire: _____

_____

_____

_____

Do you wish to:

- □ Arrange an appointment to inspect the requested information
- □ Receive a copy of this information

Instructions regarding copies:

- □ I will pick up the copies
- □ Please mail the copies to me at the following address:

_____

This request was signed by: _____

Patient name or representative – please print

Relationship to patient (if other than patient):_____

Date: _____

There will be a $15.00 fee for medical records released to patients. _____

Patient signature acknowledging fee