Patient Access to Records Request Form (04/14/03)

Implemented 04/14/03

Name: _____ DOB / ID #: _____

Address: _____ Phone #: _____

Record Holder: _____ Date of Request: _____/_____/_____

I am asking for access to my information for the following time period:

From: _____ To: _____

I understand that the City has thirty (30) days after receipt of this request to respond unless the requested information is off-site, in which case the response time is sixty (60) days. In addition, the City may notify me in writing that an extension of up to thirty (30) days is needed. I understand I will be responsible for the cost associated with copying or summarizing my health information. Fees will be reasonable and cost-based, and include only the cost of copying and postage.

I understand that I may be denied access to certain health information, including (1) information that is not held in the designated record set; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of litigation; and (4) other information not subject to the right to access information under state or federal law.

_____ _____

Signature of the Patient or Legal Representative Date

Approved ☐ Denied ☐ Delayed ☐

If delayed, we will act on your request by: _____

Comments: _____

_____

_____

_____

_____

Staff Signature: _____ Date: _____/_____/_____