

# Dr. Stephen C. Brown

## Request for Records/Access

Privacy Official Name: Belita Jean B. Telephone: (540) 374-1010 or (804) 768-9000

Patients Name (print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (for identification purposes)

Describe the records you wish you access and the approximate dates of the records: \_\_\_\_\_

### What would you like for us to do for you?

- I wish to see the requested records.
- I wish to get a copy of the requested records.
- I wish to see and get a copy of the requested records.

If the requested records are in an electronic designated record set, I wish an electronic copy of the requested records the following form and format, if readily producible : \_\_\_\_\_

\_\_\_\_\_

I would like the information emailed to: \_\_\_\_\_@\_\_\_\_\_

**We do not recommend sending patient information in an unencrypted email because third parties may be able to access the email.**

- I want you to provide the requested records and I agree to pay a fee in the amount of \$ \_\_\_\_\_.
- I want to prepare and explanation of the records that I saw or got a copy of, and I agree in advance to pay a fee in the amount of \$ \_\_\_\_\_.
- I want you to send the copy of the requested records to:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

### Questions?

Please contact our privacy official listed at the top of this page if you have any questions about your request to inspect or copy records.

### ***If the request is by a patient:***

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

### ***If the request is by a patient's personal representative:***

Print the Name of the Personal Representative: \_\_\_\_\_ Relationship to the Patient: \_\_\_\_\_

I certify that I have legal authority under federal and state laws to make this request on behalf of the patient identified above.

Signature of Personal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

Records were provided on this Date: \_\_\_\_\_ Staff Liaison Signature: \_\_\_\_\_