

Dr. Stephen C. Brown

Request for Records/Access

Privacy Official Name: _____ Telephone: _____

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: _____