F. READ HOPKINS PEDIATRIC ASSOCIATES, INC.
Request for Access to Personal Health Information

Patient Name: _____ DOB: _____

Address: _____

City-State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

☐ I would like a copy of my health information
I understand I may be charged a reasonable cost based fee.

☐ I would like to review my health information

☐ I would like for my health information to be provided to a third party:

- Name of third party: _____
- Address: _____ Phone: _____

Information requested:

☐ Immunization record ☐ Summary ☐ Laboratory/x-ray reports
☐ Other (specify) _____

Optional – Purpose for request: ☐ Change of provider ☐ Relocation ☐ Personal use
☐ Other _____

I understand I may be charged a reasonable cost based fee.

Select the format you would prefer:

☐ Paper
☐ Mail to above address
☐ Will pick up at the practice

☐ Electronically
☐ Flash Drive/CD
☐ Email

☐ Fax Number: _____

☐ Patient Portal

Email address: _____

- For **email communication,** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. By providing my email address I elect to receive email communication as requested.

☐ I would like a written summary of the requested information.
I understand that I may be charged a reasonable cost based fee.

This access request will be processed no later than 30 days from the date received. There are limited circumstances in which your request may be denied, in which you will be notified and may have the right to request a review of the decision.

_____ Date _____
Signature of Patient or Personal Representative

*Description of Personal Representative's Authority, if other than biological parent. (attach documentation)

Forward this request to Records custodian