REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____

RE: Medical Records Maintained by PEARL CITY MEDICAL ASSOCIATES, INC.

☐ Request for access to review entire medical record.

☐ Request for access to specific documents (describe): _____
_____

☐ Request for copies of the following:
- ☐ Complete medical record
- ☐ Copies of records pertaining to the period from _____ to _____
- ☐ Copies of specific documents (describe):
  _____ Dates: _____
  _____ Dates: _____

☐ Request for a summary of services provided to me during the period from:
_____ to _____

Reason for Request: _____

☐ Mail copies to me at this address: _____

☐ Call me at _____ when copies are ready for pickup.

☐ I authorize _____ to pickup the copies on my behalf.

I understand that:
- There will be a copying charge of $ .50 per page.
- The cost of preparing a summary will be a minimum of $50.00.
- Payment must be remitted before the copies of the records are released.
- The law requires Pearl City Medical Associates, Inc. to act on this request within 30 days (60 days, if records are off-site). If additional time is required, an extension of 30 days is permitted, and I will be notified of any delay.
- The law may require denial of access in certain circumstances. I will be notified in writing if access is denied and the reasons for denial.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Print Name of Authorized Representative* (if applicable) Relationship to Patient*
* Attach documentation of authorization

FOR OFFICE USE:
Copies released on: _____ Via: Mail ☐ Fax: ☐ Pickup: ☐
Access not permitted (indicate reason): _____
Letter sent to patient on: _____
By: _____