PATIENT REQUEST FOR COPY OF MEDICAL RECORD

As a patient of ASSOCIATES IN WOMENS HEALTH, L.L.C., you are entitled under federal law to access your personal protected health information maintained in a "designated record set." In order to process your request for access to this information, please complete this form and submit it to the Privacy Officer. When received by the Privacy Officer, she will use the information to verify your identity and process your request. If you have any questions or concerns, please contact the Privacy Officer, Aprile Snyder, at (402) 614-7421. Our fax number is (402) 697-7282.

Patient Information

Patient Name: ____ Patient Account Number: ____________

SSN: ____________________ Birth Date: _____________ Date of Access Request: ______________

Description of Records Requested:

(Please describe the specific records or types of records requested and the dates or time frame of records requested. Write "Complete Medical Record" if you would like the entire chart).

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Scope of Request:

Please let us know if you want to:

____________ I would like to obtain a *copy* of the requested records.
____________ I would like to *inspect* the requested records.
____________ I would like to *both a copy and inspect* the requested records.

Fee for Copying Requested Records

Our practice may charge a reasonable fee for the cost of copying your requested records. We may also charge you for postage if you ask us to mail your requested records.

Delivery Method

[ ] I will return to Associates in Womens Health, L.L.C. and pick up the copy when it is ready (Lakeside Medical Plaza, 17001 Lakeside Hills Plaza, Suite 100).

[ ] I would like Associates in Womens Health, L.L.C. to send the copy via U.S. mail to the following address: ____

[ ] I would like Associates in Womens Health, L.L.C. to send the copy via facsimile to the following number: ___________________________.

I understand that Associates in Womens Health, L.L.C. is given ten days to process my request for access or thirty days to provide a copy of my requested records. Associates in Womens Health, L.L.C. may extend the deadline by an additional twenty-one days for access if I am notified in writing of the extension. I further understand that my rights are limited to any information in my "designated record set" as defined in Section 164.501 of the Code of Federal Regulations.

By signing below, I acknowledge and agree to the above conditions.

____ _______________________
Signature of Patient or Personal Representative Date

____ _______________________
Printed Name of Personal Representative (if applicable) Relationship

06/01/2022