

PORTAGE FOOT CLINIC

Form 17 - Patient Access to the Medical Record Request Form

I, _____, request access to my medical records for my personal inspection or by _____, my personal representative. (Please request date and time requested for record access)
Date _____ Time _____

OR

I, _____, request PORTAGE FOOT CLINIC make copies of my medical records for my personal inspection. I understand that these records contain protected health information (PHI). I agree to be responsible for the cost of copying these records, including copying fees, labor, supplies, and postage (if applicable). The charge for this will be \$ 1.00 per page* and I will be charged a minimum of \$ 10.00. I agree to pay for this prior to the service being rendered.

Patient Signature _____
Patient Printed Name and Date of Birth _____

Date of request _____

Practice Response to Request (Must be within 60 days of receipt of request.)

Grants all or part of your request _____
 Denies all or part of your request _____

For the following reason: (Circle all that apply)

Not part of your designated record set; contains psychotherapy notes; information was compiled for civil, criminal or administrative actions; subject to CLIA; regards inmate at correctional institution; was created during research; is subject to Federal privacy act; was not created by this practice.

Patient may not appeal if denial is for any of the above reasons

Denied at the discretion of the practice as the information may be harmful to the patient or a third party
 Requests a 30-day extension to respond due to _____