REQUEST TO INSPECT & RECEIVE A COPY OF PROTECTED HEALTH INFORMATION

Date of Request: _____Date of Birth: _____
Patient's Name: _____
Patient's Address: _____

I would like to inspect and/or receive a copy of my protected health information. I understand that any inspection of my protected health information will occur in my health care provider's office and that I am not allowed to remove my file from such office. I also understand that, if I am allowed copies of my protected health information, my health care provider will arrange for the copying of such information.

I understand that I cannot have access to (1) psychotherapy notes or to (2) information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

I understand that my health care provider may impose a reasonable, cost–based fee, i.e., labor, supplies, and postage, for the copying of my protected health information, and that I must pay such fee before my protected health information will be released to me.

I further understand that if my request to inspect and copy my protected health information is accepted, my health care provider will permit inspection of such records within five (5) working days of my written request, and/or provide copies of such records within fifteen (15) days of my written request. I also understand that my health care provider may decide to deny the request. Written notice of such a denial will be provided to me within thirty 30 days of my written request. In addition, my health care provider may require a one-time extension of up to thirty (30) days to respond to the request.

I further understand that my health care provider may provide me with a summary of my protected health information if I agree in advance to receive such summary and I agree in advance to the fee imposed for preparing such summary.

I have consulted with my health care provider and I agree to accept a summary of my protected health information in lieu of receiving copies of my protected health information: Yes _____ No _____. And, I agree to pay $_____ for such summary.

Signature of patient or representative: _____

If representative, give relationship: _____

Please mail request to:
Brooks Foot & Ankle Associates
C/O Kristie Moore, Privacy Officer
2201 E Nine Mile Rd
Pensacola FL 32514

You will be contacted when your records are ready and if any fee is due.