Canandaigua Orthopaedic Associates, P.C.

PATIENT REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION (PHI)

229 Parrish Street • Suite 100 • Canandaigua New York 14424
Phone 585.394.1960 • Fax 585.393.9232

REQUEST

I request the following (check all that apply)

_____ that the Practice provide me with a copy of the PHI

_____ that the Practice allow me to inspect the protected health information relating to me that is described below (PHI); and

FORM OF ACCESS

I understand that the Practice will provide me with access to the PHI in readable hard copy form unless I request some other form or format. The Practice will comply with my request for an alternate form or format only if the Practice can readily produce the PHI in that form or format. I hereby request an alternate form or format described as follows.

_____

SUMMARY/EXPLANATION

If I agree, the Practice may provide me with a summary or explanation of the PHI in lieu of providing access to the PHI. However, I must also agree to pay the Practice a fee to create such a summary or explanation. I do not (do) request a summary or explanation of my PHI.

FEES

If I request a copy of my PHI, I understand that the Practice may charge me a reasonable cost-based fee to respond to this request, but the charge for paper copies shall not exceed $.75 per page and $10.00 per disc for xray duplication. The Practice may also charge me for postage if I request that the Practice mail the PHI to me. I do (do not) request that the Practice mail the PHI to me.

TIME TO RESPOND

I understand that the Practice has 10 days after receipt of this request to provide me with an opportunity to inspect the PHI and a reasonable amount of time to provide me with a copy of the PHI, which shall not be less than 10 or more than 60 days.

DENIAL OF ACCESS

I understand that there are reasons why the Practice may deny in whole or in part, my request to inspect and/or copy the PHI. I further understand that the Practice will provide me with written notice of any such denial, and in what circumstances and how I may request a review of that denial.

REASON FOR MEDICAL RECORD/XRAY COPIES_____

TIME PERIOD COVERED *(ex. PHI for care provided from 01/01/12 to 05/30/15)* _____

MAIL/FAX TO _____

Patient Name *(printed)* _____DOB _____

_____Date _____

Patient signature

Patient Mailing Address _____ Phone Number _____

_____ Date _____

Representative signature *(parent or guardian if patient is a minor)*

Relationship to Patient *(ex. Attorney-In-Fact, Guardian, Parent of Minor)* _____

REVISED 8/2019