

**Physician Practice
ACCESS REQUEST FORM**

Patient's Name:			
	Last	First	Middle
Home Address:			
Home Phone:		Date of Birth:	

- I hereby request that the Practice provide me with **[please check all boxes that apply]**
- access to a copy of the "Requested Information" checked below:
- My medical records.
 - My billing records.
 - Any other personally identifiable information used by the Practice to make medical decisions about me.

Please check one of the following boxes:

- I am only interested in accessing or obtaining a copy of Requested Information relating to the time period _____ through _____.
- I am interested in accessing or obtaining a copy of all Requested Information maintained by the Practice.

I understand that any information provided to me pursuant to this request will not include (i) information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be required by applicable law; or (ii) if I am a parent or legal guardian requesting access to a minor's information, records related to certain portions of the minor's medical record will not be accessible to me (for example, records relating to pregnancy, abortion, sexually transmitted disease, substance use and abuse, and contraception and/or family planning services).

I understand that the Practice may deny this request under limited circumstances permitted by federal and state law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by the Practice who did not participate in the Practice's decision to deny my request.

I understand that the Practice will notify me of its decision to approve or deny my request to access or obtain a copy of the Requested Information within thirty (30) days of receiving this request.

I would prefer to: pick-up or view the Requested Information at a mutually agreeable time and place; have the Requested Information mailed to me at the following address:

I understand that the Practice will charge me an administration fee of \$10.00 plus **\$1.00** per page for copying fees necessary to complete my request, as well as any applicable mailing fees. **[No more than \$1.00 per page or \$100 for the entire record, whichever is less]**. If I am granted access to the Requested Information, I **[please check the appropriate box]** would would not like the Practice to provide me with an additional written explanation of such Requested Information at an additional cost to me of [\$_____].

Signature of Patient (or Personal Representative)

Date

Printed name of Personal Representative

Relationship to Patient

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After you have completed this form please return it to the Office Manager by mail or by facsimile at the following address: Office Manager, Cumberland Orthopedic P.A., 2848 S. Delsea Drive, Vineland, New Jersey 08360. Fax: 856-696-3689