Staff Initials: _____
Invoice #: _____

PORT Health Services

PERSON'S ACCESS TO MEDICAL RECORD

Please use this form to request access to your medical record, either to review your protected health information or request copies.

If you are approved to review your records, you may make an appointment with your clinician to address your questions. You may contest the information contained in the record. No portion of the original written record shall be deleted and no correction shall be made in the original record unless the designated employee concurs that such information is justified through the REQUEST FOR AMENDMENT procedure. You may add a statement to the record if a correction cannot be made.

If you are approved to receive copies of your medical record, you will be responsible for:

- a $6.50 fee if you pick up your records in person in paper form
- a $6.50 fee plus postage if records are mailed to you
- a $6.50 fee if you requested an electronic copy.
- If you choose to receive a summary of your protected health information instead of copies of your medical record, you will be responsible for a $11.50 fee plus postage if the summary is mailed to you.

We usually respond to requests for access within 30 days of receiving them according to HIPAA law. Please note that HIPAA allows one 30-day extension to respond to your request and we will notify you in writing of the delay and state when you can expect a response.

If, however, there are circumstances when you need your records earlier than 30 days, please list the date that you need them: _____*(date)*
Efforts will be made to satisfy your request if feasible.

Please complete, sign the top section on the next page and return to the front desk staff.

PORT HEALTH

MEDICAL RECORD REQUEST

Patient Name: _____ DOB: _____

Requestor Name: _____ Relationship to Patient: _____

Phone No.: _____

Please complete the following information and check all the appropriate boxes

Dates of services associated with request (specific treatment dates or periods) _____

If requesting copies, describe the reason for the request:

☐ Coordination of Care ☐ Legal Purposes ☐ Billing ☐ Beneficial Benefits

☐ Other (Please specify): _____

Describe the information you are requesting to view or obtain copies:

☐ Assessment ☐ Labs ☐ Progress Notes ☐ Medications

☐ Other (Please specify): _____

Delivery Method of Records Accessed (if requesting copies of records, please select the delivery method):

☐ Pick up the records in person in paper form

☐ Mail records to (print name & address): _____

_____

☐ Send records to email (print email address):_____

☐ Summary of the requested protected health information instead of copies of the medical record.

All requests will be handled within 30 days. For urgent requests, list date here: _____

Signature: _____ Date: _____

Review of Denial Right: If your request is denied in whole or in part as indicated below, you have the right to request a review of the denial. If you want to exercise this right, complete the *Request for Review of Denial* form and return it to the clinic. A review will be conducted by a licensed health care professional who did not participate in the original decision to deny your request.

Complaint Right: If you have concerns about this procedure, you may file a complaint by contacting PORT Health Services, Attention: Compliance & Privacy Professional, 154 Beacon Drive, Suite I, Winterville, NC 28590.
Telephone: 252-353-1114 Online: https://www.porthealth.org/quality-improvement/grievance

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FOR OFFICE USE ONLY

Determination of Request

☐ Request is approved (Route form to Releases Staff for invoice and copies (if applicable). Upload form in EHR and send with record copies.)

☐ Request is denied ☐ in Whole or ☐ in Part (Upload in EHR and send this form to patient with a 'Request for Review of Denial' form and the accessible records if "in Part" is checked.

Reason for Denial: A licensed health care professional has determined, in the exercise of professional judgment that:

☐ The access requested is reasonably likely to endanger the life or physical safety of the patient or another person.

☐ The records mention another person (other than health care provider) and release of the information may cause substantial harm to the other person.

☐ The request of access to records was made by the patient's legal representative and the release of records to such person may cause substantial harm to the patient or another person.

_____ _____

Printed Name and Signature of Health Care Professional Date