



The Spine Care Center & Spine Care Associates

Restoring Function. Relieving Pain.

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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 **The Spine Care Center** 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 fee will be an initial charge of \$15.00 with a cost of \$.50 per page up to 25 pages. After 25 pages \$.25 will be charged per page. 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 _____