PATIENT REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

Medical Associates Clinic, P.C. & Affiliated Entities

Release of Information: 1500 Associates Drive, Dubuque, IA 52002
Telephone 563-584-3207; FAX 563-584-3216
(Important: PRINT information)

Patient's Full Name____MRN__________________________

Previous Name/s (if any)____ Date of Birth______________

Address____

Daytime Phone____Last 4 digits of social #______________

I request to receive and/or review the protected health information held about me in Medical Associates Clinic's designated record set, which may include the following information: medical records, mental health records, and billing and payment records. Please provide us with the information requested below; failure to complete this section may result in a delay in processing your request.

Indicate the information to be received:

☐ I only need (Specify here if you only need notes from one MD or Department or only lab or x-ray results, or ADHD, or other specifics):____

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☐ Complete medical record

☐ Billing and payment information (Business Office)

I would like to receive my information:

☐ I request to pick up the copy in person

☐ I request an electronic copy

☐ I request that you mail the copy to me via US mail to the following address: ______________________________

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☐ I request that I be permitted to review my protected health information in person. Please contact me about arranging a review of my information.
I can be contacted at my home / cell phone ____________________ **work phone** ____________________

On the following date and time ____

Is there any sensitive information you would like excluded such as substance abuse, mental health, AIDS/HIV diagnosis, and/or any test results?

I agree to pay any fees for copying my health information as established by Medical Associates Clinic, P.C. and/or Affiliated Entities. I understand that my request does not apply to certain health information, including: (1) information that is not held in the medical record; (2) psychotherapy notes as defined under HIPAA; (3) information compiled in reasonable anticipation of or for litigation; and (4) other information not subject to the right to access information under the HIPAA Privacy Rule.

This agreement will expire one year from the date of signature, but in no case valid for more than one year, or as indicated (specify number of days or months) ____________________ unless cancelled by the patient or guardian.

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Signature of Patient or Legal Guardian Printed Name Date

Relationship to Patient (Parent, Guardian, Health Care POA, etc.) ______________________________

PROCESSING OF AUTHORIZATIONS MAY REQUIRE 30 DAYS FROM DATE RECEIVED AT MEDICAL ASSOCIATES CLINIC, P.C.
If additional time is necessary, we will notify you. You will receive a written notice regarding our decision only if the decision is to deny your request. If your request is approved, we will call you to advise of any applicable fees, and the time frames in which to expect availability of access. In the event that we deny your request, in certain situations you have the option to request a review of that decision. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.