INTERVENTIONAL
SPINE & SPORTS
MEDICINE, PC

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Patient Name _____ D.O.B._____

Address _____Phone_____

I am requesting access to my protected health information that is currently maintained by Interventional Spine & Sports Medicine, PC (ISSM).

I would like to access my protected health information by (check all that apply):

____ Inspecting my protected health Information. If my request is approved, ISSM will contact me at the address listed above to instruct me how to arrange for a convenient time and location to inspect my requested protected health information.

____ Obtaining a copy of my protected health information.

Would you accept a summary or explanation of your protected health information in lieu of access? Yes / No

____ If my request is approved, ISSM will mail my requested protected health information to the address listed above.

____ If you prefer to pick up your information from ISSM during normal business hours, please check here _____.

I request the following access to my protected health information:

____ All of my protected health information.

____ Some of my protected health information as follows: (Include specific dates, etc. to assist ISSM in providing access to a portion of your Information.)

_____

I understand that my rights with regard to this request for access are set forth in ISSM's Notice of Privacy Practices.

By signing this form, I agree to pay the reasonable costs of preparing, copying, mailing or other supplies and labor associated with my request, up to the maximum allowed by law.

_____

Patient Signature Date

_____

Printed Name