The Women's HEALTH GROUP
www.whg-pc.com

REQUEST FOR ACCESS TO MEDICAL RECORDS

You are entitled under federal law to access your personal protected information maintained in a "designated record set." This means that you have the right to view and/or obtain a copy of your medical record. Review and copying may be denied in limited circumstances. This would happen if the provider, in exercising professional judgment, reasonably believes that the disclosure would cause harm to the patient.

Patient Name: _____ **Date of Birth**: _____

Date Request Made: _____

Method of Access Requested:

☐ I would like to **view** my protected health information. I will *schedule an appointment* with The Women's Health Group, PLLC to view my information. I understand that a staff member of The Women's Health Group, PLLC will sit down with me as I review my health information.

☐ I would like a **copy** of my protected health information. I understand that The Women's Health Group, PLLC will charge me copying fees as follows: **$18.50 for the first ten pages, $0.85 for each additional page through page 40, and $0.57 per page after page 40.** I understand that I may also be charged actual postage fees if I choose to have my records mailed to me. I understand that I will be required to pay the fee in full prior to receiving my records.

☐ I would like The Women's Health Group, PLLC to provide to me an explanation or summary of the information provided. I understand that The Women's Health Group, PLLC will charge me $_____ for the explanation or summary, and that I will be required to pay the fee in full before I can obtain the explanation or summary.

Delivery Method Requested:

☐ I will return to The Women's Health Group, PLLC and pick up the copy when it is ready.

☐ I would like The Women's Health Group, PLLC to send the copy via U.S. mail to the following address:

_____

_____

☐ Other method requested, if reasonable (request may not be honored):

_____

I understand that The Women's Health Group, PLLC is **given thirty days to process my request** for access if my information is maintained on-site and that The Women's Health Group, PLLC may extend the deadline by an additional thirty days if I am notified in writing of the extension for good cause.

I acknowledge and agree to the above conditions.

_____ _____

Patient Signature Date

Please fax completed form back to our Broomfield location at (303)460-8204