NW CYPRESS
PEDIATRICS AND FAMILY MEDICINE

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NW Cypress Pediatrics and Family Medicine

Patient request for access to protected health information

This form must be submitted by patients to request inspection and/or copies of their protected health information. Please read the instruction page (attached) before completing this form.

I. Patient name: _____ Birth date: _____

Mailing address: _____Home phone: _____

City, State, ZIP: _____ Dates of service: _____

II. I wish to (check one): _____Inspect the record _____Obtain copies of the record. (See fees on instruction page.)

III. I want to inspect or obtain copies of the following reports:

( ) Abstract - includes face sheet, discharge summary, history and physical exam, operative and pathology reports, consultation reports, radiology reports and EEGs

Or:

( ) Discharge summary
( ) History and physical exam
( ) Consultation reports
( ) Progress notes
( ) Radiology reports
( ) Laboratory reports
( ) Pathology reports
( ) Operative reports
( ) Clinic/outpatient record
Which clinic or doctor? _____
( ) Billing claim forms
( ) Itemized statement of charges
( ) Other, specify: _____
( ) All information

Or, for mental health records (may require physician/psychologist approval):

( ) Psychiatric/mental health records
( ) Neuropsychological testing
( ) All information
( ) LSC/CAP records
( ) Other, specify: _____

Please note that currently NW Cypress Pediatrics and Family Medicine can provide only paper copies for most reports.

IV. I request NW Cypress Pediatrics and Family Medicine to provide me with access to the protected health information as described above. I understand:

- The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes.
- NW Cypress Pediatrics and Family Medicine, PLLC reserves the right to verify my identity/guardianship
- I will be charged for copies that I have requested.

Signature: _____ Date_____

Printed name: _____ Relationship to patient: _____

V. Mail copies to (address): _____

City, State, ZIP: _____

Or, if you wish to pick up the copies, give phone number to call: _____

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Mail or deliver completed form to } NW Cypress Pediatrics and Family Medicine
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