

TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.

Main Office: 1405 Centerville Road, Suite 5400, Tallahassee, Florida 32308

Office: (850) 877-0101, Fax (850) 877-2750

Request for Access to Patient's Health Information

As a patient of Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A., you are entitled under federal law to access your personal protected health information. You may obtain a copy and/or view the information. Please return your completed form to our office. We will use the information to verify your identity and process your request. Photo identification may be requested at any time. If you have any questions or concerns, call (850) 877-0101.

PATIENT NAME: _____ **DATE OF BIRTH:** _____

REQUEST COPIES OF MY MEDICAL RECORDS

FROM: Name: _____

Address: _____

City/State/Zip: _____

RELEASE COPIES OF MY MEDICAL RECORDS

TO: Name: _____

Address: _____

City/State/Zip: _____

***I request the following and I understand that there may be a charge for these services:
(Please check appropriate box)***

TO PICK-UP COPY **TO FAX to #** _____ **or** **MAILTO ADDRESS ABOVE**

VIEW: I would like to view my protected health information by scheduling an appointment.

I understand that authorizing this disclosure of medical records is voluntary and that I do not need to sign this form in order to receive treatment. Once this information is disclosed, the information is no longer protected by federal privacy regulations.

I understand that I may revoke this authorization at any time and I must do so in writing.

I understand that Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A is allowed 30 days to process my request for access of my information if maintained on-site, 60 days if the information is maintained off-site, and that the deadline may be extended an additional 30 days if notified in writing of the need for an extension. I further understand that my rights are limited to any information in my "designated record set" as defined in Section 164.501 of the Code of Federal Regulations.

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency syndrome (HIV), behavior or mental health services and/or treatment for alcohol or drug abuse. I agree to such release. **INITIAL AND DATE:** _____

By signing below, I acknowledge and agree to the above conditions.

Signature of Patient

Date

Witness

Fees Collected ID Verified

INTERNAL USE ONLY

Completed By: _____ Processed Date: _____