Ear, Nose, Throat & Plastic Surgery Associates, P.C.

PATIENT REQUEST FOR ACCESS TO RECORDS

Patient Name: ______________________________________ Date of Birth: ________________

I am requesting that Ear, Nose, Throat & Plastic Surgery Associates, PC provide me access to my medical and/or billing reports in the following manner:

□ Paper copy (specify: will pick up or mailed) □ Emailed copy □ Faxed copy

Email or fax to send to: ____

Describe the records you are requesting and the reason for such access:

□ My Medical Record (visits, reports, labs, imaging, etc.) □ My Billing Record □ My appointment information

□ All health information related to _____________ □ Other: ____

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I understand that I may be charged a reasonable fee for copying, digital media, postage and the preparation of the requested information.

____ ______________________
Signature of Patient or Legal Representative **Date**

____ __________________________________
Relation of Representative **Witness**

FOR OFFICE USE ONLY

Request Received on ____/____/____ by ___________________________
Upon reviewing Patient's request, ENT Associates:
[ ] Agrees to request
[ ] Does not agree to request
Comments: ____

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____ ____________________
Privacy Officer Signature **Date**