ALLERGY PARTNERS

Allergy Partners Address: _____

City, State Zip Code

Phone:_____ **Fax:** _____

PATIENT REQUEST FOR MEDICAL RECORDS

Patient Name:

_____ _____ _____

First Middle Last

Patient Date of Birth: _____**Phone Number:** _____

Patient Address:

_____ _____ _____

Street City State & Zip

I hereby request/authorize Allergy Partners to:

☐ Release to Me/My Personal Representative

☐ Release to the Person or Entity Named and at the Address Provided Below:

Name: _____

Phone:_____ **Fax, if Health Care Provider:** _____

Address:

_____ _____ _____

Street City, State Zip Code

Special Authorization: My evaluation, diagnosis, and/or treatment information may be released to the person or entity noted above as authorized by my initials next to any of the following information to be released: _____*Behavioral Health* _____*HIV/AIDS/STD* _____*Alcohol &/or drug abuse or dependence*

Medical Record Information to be Released:

☐ All items below or check individual records requested:
☐ Clinical Visit / Office Visit Notes
☐ Immunotherapy Testing
☐ Extract Formulation
☐ Pulmonary Function Test(s)/Spirometry
☐ Allergy Injection Record
☐ Blood Test Results

☐ Biopsy / Pathology Results
☐ Radiology Reports
☐ Methacholine Challenge
☐ Echocardiogram / Stress Test
☐ Sleep Study Report
☐ 24hr pH Probe Reports
☐ Other: _____
(please specify)

Date/Time Period of Information Requested:
Specify date/time period for the information above:
From: _____ **To:** _____

Format Requested/Delivery Method:
Allergy Partners will provide in the format requested if it is readily producible in such format. If not, Allergy Partners will provide in a readable hard copy or other format agreed to by Allergy Partners and the requesting individual.

☐ View On-Site (time must be scheduled in coordination with the Allergy Partners office)
☐ Mail paper records to address listed above
☐ Send in Patient Portal
☐ Fax to: _____
☐ Receive by email (may be size limitations) - check one and print email address below:
☐Secure/encrypted ☐Regular/unencrypted – Initials here _____*
Email: _____
*By my initials, I acknowledge there is some level of risk that information in a regular (unencrypted) email could be read by someone other than me. I accept this risk.

☐ Electronic Format (describe): _____ (fee may apply)
☐ Alternate format and any applicable fee as agreed to by Allergy Partners and me:
_____
Fee: _____

Information Excepted from Request:
I understand that any information provided to me pursuant to this request will not include information compiled in reasonable anticipation of (or for use in) a civil, criminal, or administrative proceeding or as may otherwise be limited or restricted by applicable law. If I am a parent or legal guardian requesting access to a minor's information, I further understand that I will not be provided access to records related to certain categories of treatment as further protected by law (for example, a minor's receipt of services with confidentiality protected under applicable state law).

Timely Response to My Request:

I understand that Allergy Partners will notify me of its decision to approve or deny my request to inspect or obtain a copy of the requested information within fifteen (15) days after the receipt of the request unless a shorter timeframe is defined under state law, in which case Allergy Partners will respond within the time designated by such state law. Should Allergy Partners need additional time to respond, Allergy Partners will provide a written statement within 30 days of receipt of the request with the reason for the delay and the date by which Allergy Partners will respond to the request, which shall not exceed 60 days from the date Allergy Partners receives the original written request.

Process if Request Denied:

I understand that Allergy Partners may deny this request under limited circumstances as provided for under federal and state law protecting the privacy of health information. If denied, Allergy Partners will provide me a timely, written explanation of the denial and, if applicable, my review rights and how to exercise them.

Fees:

As a courtesy, Allergy Partners will not charge the patient for the first copy of records requested each calendar year, but may do so for additional requests within the same calendar year. I understand that if I request my records more than one time in a calendar year, Allergy Partners may charge a fee for any copying services necessary to complete my request related to release to someone other than me/my personal representative or another healthcare provider, as well as any applicable mailing fees. Further, Allergy Partners may charge a fee, as applicable, for providing a summary of the requested information or providing the information in an alternative format. Allergy Partners will notify me in advance of any fees to be charged.

This Request/Authorization will expire six months after the date signed below.

_____ _____/_____/_____

Signature of Patient/Personal Representative: Date:

Printed Name of Patient/Personal Representative: _____

Relationship to Patient if Personal Representative: _____

TO BE COMPLETED BY ALLERGY PARTNERS PRACTICE HUB:

Date Request Received: _____

This request of PHI meets an exception to the right of access under the HIPAA Privacy Rule ☐
Exception Reason:

Request may be denied under policy HP3007-21 and request routed to the DCP on_____

Request is for electronic PHI and request routed to the DCP on _____

Request Approved ☐

Delivery:

- ☐ Viewed Only on: _____
- ☐ Picked-up on: _____
- ☐ Mailed on: _____
- ☐ Uploaded to Patient Portal on: _____
- ☐ Faxed on: _____
- ☐ Emailed on: _____
  - ☐ Encrypted ☐Unencrypted and verified initialed by patient/representative

This section completed by (name): _____

TO BE COMPLETED BY ALLERGY PARTNERS DEPARTMENT OF CCOMPLIANCE & PRIVACY:

Request Denied or Partially Denied ☐

Denial Type:

- ☐ Denial wherein the individual must be given an opportunity to appeal the denial or have the denial reviewed (*rarely occurs at AP*).
- ☐ Denial wherein the individual does not have a right to an opportunity to have the denial reviewed (*uncommonly occurs at AP*).

Timely, written explanation of the denial and, if applicable, the individual's review rights and how to exercise them provided on

Request for electronic PHI, follow Policy CIB1001-21 and indicate outcome below:

_____

This section completed by (name): _____