Allergy Partners Address: ____

City, State Zip Code

Phone:___________________Fax: __________________

PATIENT REQUEST FOR MEDICAL RECORDS

Patient Name:

____________________ ____________________ ______________________________

First Middle Last

Patient Date of Birth: ________________________

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:

____

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:

☐ Entire Record
☐ 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:
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's office)
- ☐ Paper Form
- ☐ Send in Patient Portal
- ☐ Fax to: _________________________
- ☐ Electronic Format __________________________________ (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 thirty (30) 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:
I understand that Allergy Partners may charge a fee for any copying services necessary to complete my request, 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.

Right to Revoke Authorization to Release to Another Person/Entity:
I have the right to revoke my authorization to release the information to another person/entity at any time except to the extent that action has been taken in reliance on the authorization. To revoke, I must submit a written request to the Attention of the Department of Compliance & Privacy at 1978 Hendersonville Rd. Ste. 130 Asheville, NC 28803. I understand that the information released may be re-released by the recipient and may no longer be protected by HIPAA (Federal regulations).

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

____ ____/____/_____
Signature of Patient/Personal Representative

____
Printed Name of Patient/Personal Representative

____
Relationship to Patient if Personal Representative

____

TO BE COMPLETED BY ALLERGY PARTNERS:

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: ________________________

This section completed by (name): _____________________________

TO BE COMPLETED BY THE DCP:

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): _____________________________