Fairfield County Bariatrics & Surgical Specialists, P.C.

Patient Records Access Form

Patient Name: ______________________________ DOB: ____________

I would like to:
______ Inspect
______ Obtain a copy of
______ Both inspect and obtain a copy of

My Protected Health Information records at this practice.

Inspection: I would like to visually inspect the following:
______ My complete medical record
______ My medical record from specific dates (from: _______ to _______)
______ A specific section of my medical record
Description: ____

Obtain Copy: I would like to obtain a copy of the following:
______ My complete medical record
______ My medical record from specific dates (from: _______ to _______)
______ A specific section of my medical record
*Description:*____

Delivery: I would like to pick up my records at the following date and time:

Date: ________________ Time: __________ Office: ______________
You must confirm pick-up with the office so that your records will be available.

Please mail the copy of my medical records to the following address:

Name: ________________________________
Address: ________________________________
____
____

Your agreement will be requested in advance for any copying or mailing fees that the practice incurs to fulfill your request. Per Connecticut General Statutes there is a reproduction fee of $.65 per page. This practice has the right to deny access, in whole or in part, to protected health information if the records are psychiatric notes, are a matter of national security or public health policy, are part of legal proceedings, were provided by a non-provider under promise of confidentiality, concerning the identity, or could place in danger your life or the lives of others.

Signature: ______________________________ Date: ____________________

Relationship (if not patient): ____

11/11 KD