



REQUEST FOR ACCESS TO PATIENT'S HEALTH INFORMATION

As a patient of Park City Healthcare, you are entitled under federal law to access to your personal protected health information maintained in a "designated record set". In order to process your request for access to this information, please complete this form and submit to the Privacy Officer. When received by the Privacy Officer, he or she will use the information to verify your identity and process your request. If you have any questions or concerns, please contact the Privacy Officer or Clinic Administrator at: 435-649-7640 Fax 435-645-7768.

PATIENT INFORMATION:

Patient Name: _____

Date of Birth: _____

Parent /Legal Guardian: _____

Phone #: _____

Access Method:

You have a right to **VIEW** your protected health information, obtain a **COPY** of the information, or both. Please indicate your preference below.

I understand that Park City Healthcare may charge me a **FEE** for the copies as set forth in the schedule:

Medical Records: \$5.00 research and retrieval,
\$.50/pg for the first 10 pages,
\$.20/ pg. for each additional page, after 100 pgs /\$.15
(CAN NOT FAX MORE THAN 25 PGS.)

X-Rays: \$15.00 per set

There is no charge to release my information to another clinic or physician. I also understand that I may be required to pay any fee in full before I can obtain the copy. I have selected my delivery method below. **If not selected, records will be left at the front desk to be picked up.**

APPROXIMATED DATE(S) OF SERVICE AND/OR TYPE OF RECORDS YOU WISH TO RECEIVE:

PLEASE RELEASE INFORMATION TO:

Name of Person or Entity Receiving Records

_____/_____
Phone / Fax Number

() FAX () MAIL () PICKED UP

Mailing Address

I understand that Park City Healthcare is given 30 days to process my request for access if my information is maintained on-site, 60 days if the information is maintained off-site, and that Park City Healthcare may extend the deadline by an additional 30 days if I am notified in writing of the 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.

By Signing Below, I acknowledge and agree to the above conditions.

Signature of Patient/Legal Guardian

Date Signed

For Office Use Only:

Date Received:	Received By:	Mailed/Faxed/Picked Up (please circle)	Date Completed:	Completed By:
----------------	--------------	---	-----------------	---------------