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Individual Patient Request for Medical Records Form
2017

Background:
Protecting patient health information is an important ongoing priority at Nephrology Associates of Syracuse, PC. Our Notice of Privacy Practices confirms that all individual patients have a right to inspect their own protected health information (PHI), obtain copies of some or their entire PHI record, direct the practice to transmit a copy of the PHI to a designated person/entity; and amend their health information.

Due to security risk, patients are not permitted to provide their own personal USB drive to capture their PHI. The practice has the ability to provide PHI upon authorization by the patient via paper or electronic format, specifically a CD. The practice requests that the patient specify whether they are only interested in certain portions of the record, such as a specific test or period of time, as this can reduce cost for both the patient and the practice. The patient must complete, sign and date this request form prior to PHI being provided to him/her.

At the current time, the practice is unable to email PHI via the patient portal and await feedback from our electronic medical record vendor as to when a PHI PDF attachment can be securely transmitted via email from the patient portal. Until this time, the practice can provide PHI upon request in an electronic format via a CD. The practice will adopt reasonable safeguards in implementing the patient's request, but is not responsible for safeguarding the information once it is delivered to the patient. The above requirements also apply when a patient directs that PHI be sent to another person/entity.

Reasonable, Cost-based Fees for Copies of PHI:

- The reasonable, cost-based fee is based on labor for copying the PHI, supplies for creating the copy, postage (if applicable) and preparation of an explanation or summary of the PHI, if applicable and agreed to by the individual
- Medical record copy fee – Paper format: the first fifty pages are free. For paper format copies of fifty pages and greater, and for electronic format, a reasonable, cost based fee will be charged. This *Individual Patient Request for Medical Records Form* or a *HIPAA Authorization Form* is available to initiate the request.

The practice will inform the patient *in advance* of the approximate fee that may be charged for the copy. Notification of the charge will be made to the patient via telephone in advance and appropriate payment arrangements will be made at that time.

Please complete the form below and return to our office via US Postal mail, fax or deliver in person. Requests will be fulfilled within 20 business days or less. Patients will be notified via phone once complete. Requests are to be picked up in person and valid identification must be provided prior to receipt of the PHI. We appreciate your cooperation. Thank you.

Last Name _____

First Name _____

Middle Initial _____

Date of Birth _____

Mailing Address _____

City _____

State _____

Zip Code _____

Please check one selection below:

____ Medical Record from (insert date) _____to (insert date) _____

____ Entire Medical Record

____ Other: _____

Paper or Electronic (CD) Format- please circle one selection

I understand that the practice has utilized reasonable safeguards in implementing my request, and the practice is not responsible for safeguarding my/the PHI once it is delivered to me.

Signature _____

Date _____