KANSAS ORTHOPAEDIC CENTER, P.A. (KOC)

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REQUEST TO ACCESS AND COPY PROTECTED HEALTH INFORMATION FORM

Patient's Name: _____ MRN: _____

Patient's Address: _____

Telephone Number: _____ Date of Birth: _____

What records do you want? (Check appropriate boxes below):

- ☐ Office Notes
- ☐ Radiology Imaging CD
- ☐ Itemized Billing Statement
- ☐ KOC Testing Reports (EMG, MRI –for tests performed at KOC)
- ☐ Short/Long Term Disability or FMLA Forms (this may include your office notes and last work status)
- ☐ Entire Record (this will not include Billing Records, X-rays or records not prepared by or on behalf of KOC unless those items also are selected)
- ☐ Records not prepared by or on behalf of KOC (such as Operative Reports, Labs, EKG, outside MRI, outside PT/OT, Consults, etc.). KOC is not responsible for the completeness or accuracy of such records.
- ☐ Other (please specify): _____
- ☐ KOC Therapy Notes
- ☐ Demographic Information

In what format would you like your records produced and how would you like your records delivered?

- ☐ **Paper (choose one)**
  - ☐ Mailing Address Delivery
  - ☐ In-Person Pickup
- ☐ **Fax**
- ☐ **Electronic-Email (choose one- if nothing selected KOC will send email encrypted):**
  - ☐ Encrypted (will need password to open)
  - ☐ Unencrypted (**Note: There is some level of risk that your protected health information could be read or otherwise assessed by a third party while in transit. By checking the box, you confirm that you've accepted this risk and request KOC to deliver your protected health information via unencrypted email).**
- ☐ **CD (choose one)-this is for medical records only, radiology images automatically come on CD**
  - ☐ Mailing Address Delivery
  - ☐ In-Person Pickup

  (choose one- if nothing selected KOC will send CD encrypted):
  - ☐ Encrypted (will need password to open)
  - ☐ Unencrypted (**Note: There is some level of risk that your protected health information could be read or otherwise assessed by a third party while in transit. By checking the box, you confirm that you've accepted this risk and request KOC to deliver your protected health information via unencrypted email).**

Where do you want the records sent? (Check appropriate boxes and complete applicable information below):

KOC should provide my records (in the format and per the delivery method noted above) to:

- ☐ Self/Personal Representative (guardian, conservator, parent, executor, administrator of estate, person acting in *loco parentis* (such as court or agency), DPOA for health care decisions) (indicated below)

  Self/Personal Representative Name: _____
  Self/Personal Representative Address: _____
  Telephone Number: _____
  Fax Number (if applicable):_____
  Email (if applicable):_____
  Relationship to Patient: _____

- ☐ Designated Third Party (indicated below- such as attorney, provider office, insurance, employer, etc.)

  Third Party Name: _____
  Third Party Address: _____
  Telephone Number: _____
  Fax Number (if applicable): _____
  Email (if applicable): _____

-OR- I hereby authorize _____ (provider or facility name and please list address, fax or contact phone number) to disclose PHI concerning the above-named person to KOC.

Fees associated with copying my protected health information:

I understand that KOC may impose a reasonable, cost-based fee for providing me with a copy of my protected health information, including: (1) labor for copying the protected health information that I requested (whether in paper or electronic form); (2) supplies for creating the paper copy or electronic copy; (3) postage, if I request delivery by mail; and (4) preparation of an explanation or summary, if I requested and agreed to the fees associated with preparation of such explanation or summary. By signing below, I agree that I have been informed of the approximate fee that may be charged for providing me with a copy of my protected health information.

We aim to process this request within 7-10 business days, but it could take up to 30 days pending the volume of requests and availability of the information requested.

_____ _____
PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE DATE

**This authorization shall remain in effect for one year from the date signed above.*

Date needed by: _____

Date request received by KOC _____ Initials of KOC Staff who received request _____

Initials of staff that completed request & date completed _____