Orthopaedic Specialty Group, P.C.
305 Black Rock Turnpike, Fairfield, CT 06825

Request for Patient Access to Health Information

As required by the Health Insurance Portability and Accountability Act of 1996 and Connecticut law, you have a right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why the request will not be granted.

I hereby request access to health information for:

_____

_____
(Print Patient's name and address)

Date of birth: _____ Social Security Number: ____-___-____

SCOPE OF ACCESS REQUESTED

I would like access to:
☐ CD of X-rays
☐ All the records or
☐ The portion of the records concerning:

_____
_____
_____
(Specify type of disease, body part, accident, dates of treatment, or other portion of records you are interested in.

If requesting copies of X-Rays: ❑ Report ❑ Images
If requesting images: ❑ CD ❑ Film ❑ Paper

TYPE OF ACCESS REQUESTED

☐ Inspection Please let me know when I may come to inspect the records. I understand that an employee of this medical practice may be present during the inspection and that I may not make any marks or alter the records in any way.

☐ Copies I would like copies of the information requested. I understand that I may be charged a fee for the copies as explained below. Please mail the records to:

_____

_____

☐ Written summary I would like a written summary of the information requested. I understand that I may be charged a fee as explained below.

CHARGES

Copies I understand that you may charge me a reasonable fee of up to $0.65 per page, including any research fees, handling fees and the cost of first class postage, if applicable, for copies of the information requested. I also understand that I may be charged a fee as necessary to cover the cost of materials for providing a copy of an x-ray.

- ☐ I hereby agree to pay the copying charges specified above.
- ☐ Please call me to let me know how much these copies will cost and to arrange payment.
- ☐ I am requesting these records be provided without charge because they are requested for purposes relating to a claim or appeal under a provision of the Social Security Act. Documentation of the claim or appeal is attached.

Written Summary I understand that I will be charged a fee of _____ for the cost of preparing the summary requested.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient.

_____

CONTACT INFORMATION Please forward

written request to:
Privacy Official
Orthopaedic Specialty Group, P.C.
305 Black Rock Turnpike
Fairfield, CT 06825

Fax request to:
Privacy Official
Orthopaedic Specialty Group, P.C.
203-337-2630

For office use only

- ☐ Records will be picked up
- ☐ Please fax records
- ☐ Please mail records
- ☐ Copy fee $ _____
- ☐ Records picked up on _____
- ☐ Payment received on _____
- ☐ Records sent on _____