

ASSOCIATED RETINAL CONSULTANTS, P.C.

**REQUEST FOR ACCESS TO HEALTH INFORMATION
TO REVIEW AND/OR RECEIVE COPIES OF MEDICAL RECORDS**

You have a right to request access to review and to receive copies of your protected health information. Please see ASSOCIATED RETINAL CONSULTANTS, P.C. ("ARC") Notice of Privacy Practices or contact ARC's Privacy Official for information.

Please submit this form to: HIPAA Privacy Official
Associated Retinal Consultants, P.C.
2000 North Huron River Drive, Suite 100
Ypsilanti, MI 48197

Patient Name _____ **Daytime telephone number** _____
Address _____ **Birth Date** _____

Please select one:

- _____ I am a patient of ARC.
- _____ I am the personal representative of a patient of ARC (*please attach proof of personal representative status*).

I would like access to the following information:

Please provide my health information dated between _____ and _____.

I am requesting this information be released to:

- 1. _____ Myself by the following method (please select one):
 - _____ Mailed copy _____ View at the Company's business offices
 - _____ Electronic copy (if available) _____ Other (describe on a separate sheet)
 - _____ I agree to accept a summary of the above requested information and to pay a reasonable charge for the costs incurred by ARC in preparing such summary.

- 2. _____ The following person or entity:

Name (Doctor/Hospital/Other) Phone Fax

Address City State Zip

Fees: You will be charged up to \$20.00 for the first 20 pages and \$.50 per page thereafter up to an additional \$5.00. The maximum you will be charged is \$25.00. This fee will need to be paid prior to or at the time of release of this information.

Please Read Carefully and Sign

I understand that ARC will provide the requested access if required to do so under applicable law. I also understand that I will be charged for copying and postage in accordance with ARC's Notice of Privacy Practices.

Signature (Relationship if not patient) Date

Please note: Applicable law requires us to respond to you within 30 days after receiving your request, unless the information requested is not maintained at our primary business address, in which case we will respond within 60 days. We are entitled, in certain circumstances, to an additional 30 days in which to respond. We will send you written notice if we determine we will need the additional 30 days.

Office use only: Total pages: _____ Total fee: _____ Initial: _____ Date payment received: _____