Pediatric Orthopaedic Associates
Next Level Sports Medicine

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

I hereby request Pediatric Orthopaedic Associates / Next Level Sports Medicine to provide me or the person listed below with access to all protected health information about me that is maintained by Pediatric Orthopaedic Associates / Next Level Sports Medicine. Specifically, I would like to:

- ☐ Inspect my protected health information;
- ☐ Inspect a summary or explanation of my protected health information;
- ☐ Obtain a copy of my protected health information; or
- ☐ Obtain a copy of a summary or explanation of my protected health information.

I would like to:

- ☐ Have Pediatric Orthopaedic Associates / Next Level Sports Medicine mail the copy

Complete medical records cannot be picked up in person. Some items can be picked up – please contact our office and ask for the records department for details.

Patient name: _____ Date of birth: _____

Name of person to receive copy (if applicable): _____

Recipient's address: _____

Recipient's e-Mail address: _____

Patient's telephone: _____ Patient Number: _____

Dates of treatment: From _____ to _____
(Write ***"all"*** if you want information for all dates of treatment)

I understand that I **may be charged a fee** for the preparation of a summary or explanation of my protected health information. I also **may be charged a fee** for reproduction costs to obtain a copy of my protected health information or to obtain a copy of the summary or explanation. If I ask to have the information mailed to me, I understand that I **may be charged a fee** for mailing costs. If I ask for an electronic copy of my protected health information, I understand that I **may be charged a fee** for the media (CD, flash drive) on which my copy is stored and provided to me and for the labor costs associated with making the copy. If I ask to have information e-mailed to me or another person, I understand that sending e-mails is not always secure, and I agree that I will not hold Pediatric Orthopaedic Associates / Next Level Sports Medicine responsible if the information e-mailed is intercepted by an unauthorized third party.

_____ _____
Signature of Patient or Representative Date

_____
Print Name

Relationship of Representative to Patient (please describe Representative's authority to act on behalf of the Patient): _____

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