COMMUNITY CARE PHYSICIANS, P.C.

PATIENT REQUEST FOR COPY OF MEDICAL RECORDS

Patient Name:____ DOB:_______________ MRN:_________________________
(First) (Last)

Address: ____ ____
(Street Address) (City, State, Zip)

Phone: ____

STEP 1: HOW WOULD YOU LIKE YOUR RECORDS?

PLEASE CHOOSE ONE:

☐ Paper Copy

☐ Faxed to the Following Number:

____

According to NYS Law, you may be charged up to $0.75 per page for these requests

☐ Electronic Copy on a USB Device Supplied By CCP:

Note: The USB device is encrypted. How would you like your password sent to you?

☐ E-mailed to the Following E-mail Address:

____

☐ Mailed to the Address Listed Above
☐ Mailed to the Following Address:

____
(Name)

____
(Street Address)

____
(City, State, Zip)

____
(Phone)

____
(Relationship to the Patient)

The charge for this request is $6.50 payable in advance.

☐ E-mail a Copy to the Following E-mail Address:

____

The charge to e-mail your records is $5.00 payable in advance. Please note that your file may be too large to e-mail. If so, you will be notified and you will need to select an alternative option above. Additional charges may apply.

STEP 2: HOW YOU WOULD LIKE TO OBTAIN YOUR RECORDS?

PLEASE CHOOSE ONE IF RECEIVING A PAPER OR USB COPY

☐ Mailed to the Address Listed Above
☐ Mailed to the Following Address:

____
(Name)

____
(Street Address)

____
(City, State, Zip)

____
(Phone)

____
(Relationship to the Patient)

☐ Pick up at the Following CCP Location:

____

STEP 3: WHICH INFORMATION WOULD YOU LIKE TO RECEIVE?

☐ Option 1: Entire Medical Record from __________ to __________.
Please note: This includes any and all HIV-related information, drug and alcohol treatment, and mental health information, if any. If the dates are not specified, then all dates will be given.

☐ Option 2: Entire Medical Record **EXCLUDING**:
☐ **HIV-Related Information**
☐ **Mental Health Information**
☐ **Alcohol/Drug Treatment**
☐ **Other (*Please be specific*):**

____

____

IMPORTANT INFORMATION

a. I understand that the content of my file is not medical advice and is not to be used or relied on for diagnosis or treatment. The content does not take the place of instructions or advice from my doctor or health care provider. I will talk to my doctor or other health care provider before making any major health care decisions based on this electronic file.
b. I understand that the information disclosed pursuant to this request may be subject to re-disclosure by the party who receives it because it may no longer be protected by the federal privacy laws.
c. I understand that records in electronic form can be distributed on a wide scale with relative ease and losses or unintended releases of the requested information may occur under circumstances beyond the control of CCP once it is in my possession. By requesting records in this format, I am knowingly and voluntarily assuming this risk and all consequences, losses and damages that might result.
d. I understand that this is not a general authorization for the release of my medical information. Specifically, I understand that I may choose not to have my HIV-related information, my alcohol and drug treatment, and my mental health information disclosed.

I agree to pay $____________ to Community Care Physicians, P.C. for fees necessary to complete my request, including but not limited to: clerical work, processing, mailing, and storage devices.

____ ______________________________
Patient/ Legal Representative Signature **Date**