Galen Medical Group, P.C.

Patient Request to Inspect and/or Copy Protected Health Information

Patient Name:	
Account Number:	Date of Birth:

I hereby request that Galen Medical Group, P.C. grant me [or the following designated individual: _____] access to

Check One: ☐ Inspect ☐ Copy ☐ Inspect & Copy

my personal health information maintained by Galen Medical Group, P.C.

If a copy of my personal health information is being requested, it should be (*check one*):

☐ picked-up by myself or the designated individual stated above.

☐ mailed to the following address: _____

With respect to the above two choices, please specify if you would prefer a paper or an electronic copy of the information: ☐ *paper copy* ☐ *electronic copy (e.g., CD or USB)*

☐ e-mailed to the following e-mail address: _____

☐ faxed to the following fax number: _____

Provide a specific description of the personal health information you are seeking to access (*include dates of service, type of service, billing records, clinical records etc.*):

_____

_____

By submitting this request I understand:

1. That Galen Medical Group, P.C. may deny my request to access my health information, with or without review, depending on the type of information I am seeking and whether Galen Medical Group, P.C. actually maintains this information.

2. If I agree, I may be provided with a summary or explanation of the health information requested, in lieu of being provided access to the information. By initialing below, I am indicating that I am willing to accept a summary or explanation of the health information I have requested and to pay all fees associated with this request.

   Your Initials: _____ Please send a summary or explanation of my health information.
   I agree to pay all fees associated with this request.

3. That Galen Medical Group, P.C. may impose a reasonable fee for accessing my health information, provided that the fee includes only the cost of:

   (a) Copying, including the cost of supplies and labor;
   (b) Postage, where I have requested that the copy or the summary/explanation be mailed; and
   (c) Preparing an explanation or summary of my health information, where I have agreed to and requested such material.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND THE TERMS AND CONDITIONS OF REQUESTING MY HEALTH INFORMATION.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Printed Name of Patient's Representative (*if applicable*)

_____

Representative's Relationship to Patient (*if applicable*)