

CAPITOL PAIN INSTITUTE PRIVACY POLICIES

2. REQUEST FOR ACCESS TO RECORDS

As a patient, you have the right to inspect and request a copy your records containing Protected Health Information. CPI has provided this form in order to facilitate such requests.

Please enter the following information:

1. Patient Name: _____
2. Patient Identification Number, if known: _____
3. Last four digits of your social security number: _____
4. Birth Date: _____
5. Address: _____
6. Phone Number: _____
7. Description of the records you want inspected or copied:

(Please provide an exact description so as not to delay disclosure. Should you require assistance, please feel free to contact CPI's Medical Records Coordinator at 512-584-8404.)

7. Records shall be provided to:

Patient

Designated Person

Name of Designated Person _____

Address/City/State/Zip _____

[NOTE: The above address will be the address where records are sent, unless you indicate you want to pick up your records directly from CPI.]

8. State the format in which you want your records (paper, via email, on an encrypted thumb drive or disk, etc.) _____

[NOTE: If you want your records via email, please execute both the Authorization and the Consent for Records to be Sent by Email.]

Signature of Patient or Legal Representative

FOR OFFICE USE ONLY

Inspection or Copying has been accepted or denied: _____

Reason for Denial: _____

Comments: _____

Signature of Medical Records Coordinator: _____ Date: _____