



# SOUTHERN BONE & JOINT SPECIALISTS, P.A.

3688 Veterans Memorial Drive • Hattiesburg, MS 39401 • (601) 554-7400 • FAX (601) 554-7499

www.southernboneandjoint.com

## REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Patient's Name: \_\_\_\_\_

**Check any of the below, as applicable:**

- I want to inspect Protected Health Information (PHI) about myself maintained in the designated record set.
- I want to obtain a copy of PHI about myself that is maintained in the designated record set.
- I request that a copy of PHI about myself be sent to a specific individual (fill out attached Authorization Form)
- I request that the PHI be provided in the following format: (circle one)
  - Paper      Portal      CD ROM      E-Mail

I understand that e-mail and postal service transmittal are both inherently insecure and that SBJ cannot guarantee or be responsible for the security or privacy of any information sent via e-mail or through the postal service. If I choose to receive a copy of my information via e-mail or by postal mail, I hereby accept any risk of unauthorized disclosure.

**MEDICAL RECORD COPY FEE SCHEDULE:**

- Electronic Copies (CD, e-mail, etc.)      **\$6.50**
- Paper Copies      **\$6.50 for first 50 pages, \$10 for more than 50 pages**
- Summary Explanation      **\$6.50 for EHR-generated summaries; \$50 for physician drafted summaries / explanations**

I understand that SBJ has thirty (30) calendar days to respond to this request and that, if someone else holds the PHI or it is off-site, the response time is longer.

I agree to pay any fees for copying, summarizing, or explaining my PHI. I understand that this request does not apply to certain PHI, including: (a) information that is not held in the designated record set; (b) psychotherapy notes; (c) information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding; and (d) other types of PHI not subject to the right to access PHI under HIPAA.

## AUTHORIZATION FOR RELEASE OF INFORMATION

This authorization for release of protected health information is provided by SBJ/SSC/SDR (the "Practice"). For information about how your medical information may be used or disclosed, please see the Patient Notice. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Compliance Officer of the Practice. The Notice is also posted at the Practice offices.

- **YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.**
- **YOU MAY REFUSE TO SIGN THIS FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED.**
- **WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION.**
- **WE WILL PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.**

*THIS AUTHORIZATION IS VOLUNTARY.*

## TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

I, (Print Patient's Name) \_\_\_\_\_, Date of Birth \_\_\_\_\_ do hereby authorize the Practice to obtain, use, disclose or receive my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that information released under this authorization may be redisclosed by the recipient of the information and may no longer be protected by state and federal law.

## ATTENTION: PATIENT OR PATIENT'S REPRESENTATIVE, PLEASE INITIAL & COMPLETE ANY OF THE APPLICABLE OPTIONS BELOW

**A ALL MEDICAL RECORDS**

I authorize the Practice to release my complete medical record (this may contain treatment notes regarding radiology, pathology *including HIV test results and genetic testing information*, immunization, procedure(s), *alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2*, and other common medical record documentation made by the physician, nurse or other ancillary personnel) for the entire time I was treated by the Practice to the following family members or friends who contact the Practice for purposes of providing them with information related to my treatment and/or payment obligations:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_



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### **B SPECIFIED MEDICAL RECORDS** (for example, for disclosure of specific information to a school official)

I authorize the Practice to release the following types of records: (description of records to be released) \_\_\_\_\_

\_\_\_\_\_

for information collected/services provided to me by the Practice during the time period of \_\_\_\_\_

\_\_\_\_\_. I authorize the Practice to release this information to the following persons:

\_\_\_\_\_ for the purpose(s) of \_\_\_\_\_.

### **C MEDICAL RECORDS TO MY EMPLOYER**

I authorize the Practice to release the following types of records: (description of records to be released) \_\_\_\_\_

\_\_\_\_\_ for information collected/services provided during the time period of: \_\_\_\_\_.

I authorize the Practice to release this information to my **employer** for the purposes of processing **FMLA forms, return to work or any other paperwork or any other information** that needs to be reported to my employer.

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Employer's City, State, Zip: \_\_\_\_\_

Employer's Phone: \_\_\_\_\_ Employer's Fax: \_\_\_\_\_

**ATTENTION: PATIENT OR PATIENT'S REPRESENTATIVE, PLEASE INITIAL THE FOLLOWING:**

I understand that the Practice may wish to contact me for purposes related to my treatment such as to remind me of appointments, leave messages that the physicians or nurse need to speak with me, to discuss financial/billing businesses, or to indicate other necessary contacts.

#### PLEASE INITIAL

\_\_\_\_\_ Yes. I authorize the Practice to contact me at the telephone numbers I have provided. I understand and authorize the Practice to leave me a voicemail message in the event that I am unavailable.

\_\_\_\_\_ No. I do not agree to these contacts. Do not leave a message.

I understand that I may withdraw my authorization in writing to the Privacy Officer of the Practice at any time, except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization, that this statement will expire **five (5) years from this date**. I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

\_\_\_\_\_  
**Signature of Patient or Patient's Representative** (Form MUST be completed before signing)

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Patient's Representative**

\_\_\_\_\_  
**Description of the Representative's Authority to Act for the Patient**

\_\_\_\_\_  
**Relationship to the Patient**