PATIENT REQUEST TO ACCESS PROTECTED HEALTH INFORMATION
Medical Associates Clinic, P.C. & Affiliated Entities

Release of Information: 1500 Associates Drive, Dubuque, IA 52002
Telephone 563-584-3207; FAX 563-584-3216
(Important: PRINT information)

Patient's Full Name_____ History #_____

Previous Name/s (if any)_____ Date of Birth_____

Address_____

Daytime Phone_____ Last 4 digits of social #_____

I request to receive and/or review the protected health information held about me in Medical Associates Clinic's designated record set, which may include the following information: medical records, mental health records, and billing and payment records. Please provide us with the information requested below; failure to complete this section may result in a delay in processing your request.

Indicate the information to be received:

☐ I only need (Specify here if you only need notes from one MD or Department or only lab or x-ray results, or ADHD, or other specifics):_____

_____

☐ Complete medical record

☐ Billing and payment information (Business Office)

I would like to receive my information:

☐ I request to pick up the copy in person **OR**

☐ I request that you mail the copy to me via US mail to the following address: _____

_____

☐ I request that I be permitted to review my protected health information in person. Please contact me about arranging a review of my information.
I can be contacted at my home phone _____ **work phone** _____
On the following date and time _____

I understand that the information to be disclosed may include information in the following categories and herby specifically authorize such disclosure:

YES Substance Abuse (drug or alcohol)
YES Mental Health (including psychotherapy notes, and/or ADHD, and/or autism)
YES AIDS/HIV-related information, diagnosis, and test results

IF YOU DO NOT WANT ANY/ALL OF THE ABOVE INFORMATION DISCLOSED, CROSS OUT "YES" AND WRITE "NO" IN THE APPLICABLE SECTION(S).

I agree to pay any fees for copying my health information as established by Medical Associates Clinic, P.C. and/or Affiliated Entities. I understand that my request does not apply to certain health information, including: (1) information that is not held in the designated record set; (2) psychotherapy notes as defined under HIPAA; (3) information compiled in reasonable anticipation of or for litigation; and (4) other information not subject to the right to access information under the HIPAA Privacy Rule.

This agreement will expire one year from the date of signature, but in no case valid for more than one year, or as indicated (specify number of days or months) _____ unless cancelled by the patient/guardian.

_____

Signature of Patient or Legal Guardian Printed name Date

Relationship to Patient (Parent, Guardian, Health Care POA, etc.) _____

PROCESSING OF AUTHORIZATIONS MAY REQUIRE 30 DAYS FROM DATE RECEIVED AT MEDICAL ASSOCIATES CLINIC, P.C.
60 days if your records are maintained off-site. If additional time is necessary, we will notify you. You will receive a written notice regarding our decision only if the decision is to deny your request. If your request is approved, we will call you to advise of any applicable fees, and the time frames in which to expect availability of access. In the event that we deny your request, in certain situations you have the option to request a review of that decision. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.