



REQUEST FOR RELEASE OF MEDICAL INFORMATION

The Practice is using this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). The Notice of Privacy Practices of Atlanta Pediatric Partners provided to our patients includes information about how we collect and use the protected health information of our patients. Our Notice also contains a section on Patient Rights that describes our patient’s rights under the current privacy law. These laws confirm that patients have the right to access, inspect, and copy the protected health care information used to make decisions about them.

The Practice is required by law to keep the original patient record. This form is to request release of your records; however, please keep in mind that any questions you may have about medical records created by another practice or health care provider must be directed to that provider. In providing access to these records:

- 1. We will only include information used to make decisions about the patient;**
- 2. We may limit access to information generated only by this Practice;**
- 3. Under some circumstances, such as increased risk of harm or injury, the Practice may withhold the requested information.**
- 4. We may also provide a summary of the requested information, if you are agreeable. This may be preferred when there is a large volume of chart pages or to provide a layman’s description of complex medical data.**
- 5. Personal identifying information such as address and insurance information will not be included.**

Our Privacy Officer will evaluate your request and notify you of our decision within fifteen (15) days of this request. If the request is approved, we will provide the information within thirty (30) days. In some circumstances, an extension of an additional thirty (30) days may be necessary, for example, if patient is not an active patient or if the chart is many years old.

If you wish to have a personal copy, reasonable costs may be charged for the request to cover our administrative costs, as well as the cost of postage or other delivery, when applicable. We will provide you with an estimated cost for this request approval of the Request and give you the option of withdrawing or amending this request.

Patient Name: _____ **Date of Birth:** _____
(Please Print)

Health Care Information requested. Please provide dates, diagnosis, treatment, or any other indications of the specific information you desire:

Reason for request: _____

Is a summary of the information acceptable? Yes ___ **No** ___

Do you wish to?

Receive a copy of the information?

If you would like a personal copy what are your instructions regarding delivery?

I will pick up the copies _____

Please mail the copies to me/other Health Care Provider at the following address:

This Request was signed by: _____
(Printed Name – Patient or Representative)

Signature: _____ **Date:** _____

Relationship to Patient (if other than patient): _____

For Office Use Only: Picked up by _____ Mailed _____ Date _____ Staff Initials _____