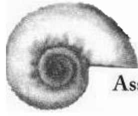

Ear, Nose & Throat
Associates of Southeastern CT, P.C.

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# REQUEST FOR PATIENT ACCESS TO HEALTH INFORMATION

Carolyn Howell, Practice Manager (860) 536-3078 ext 313

As required by the Health Insurance Portability and Accountability Act of 1996 and Connecticut law, you have a right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant or explain the reason why the request will not be granted.

I hereby request access to health information for:

______________________________________________________________________

patient's name                                        address

______________________________________________________________________

DOB                                        Social Security Number

**SCOPE OF ACCESS REQUESTED:**

I would like access to:                ☐ all the records *or*

☐ the portion of the records concerning:

______________________________________________________________________

______________________________________________________________________

**TYPE OF ACCESS REQUESTED:**

☐ Inspection. Please let me know when I may come to inspect the records. I understand that an employee of this medical practice may be present during the inspection and that I may not make any marks or alter the records in any way.

☐ Copies. I would like copies of the information requested. I understand that I may be charged a fee for the copies as explained below. Please mail the records to:____________________________________________________________

☐ Release: I would like copies of the information from Dr.__________________________________________________
released to Dr.______________________________ at Ear, Nose and Throat Associates of Southeastern Connecticut

**CHARGES**

**Copies**: I understand that you may charge me a reasonable fee of up to $0.45 per page, including any research fees, handling fees and the cost of first class postage, if applicable, for copies of information requested.

☐ I hereby agree to pay the copying charges specified above. Please bill me.

☐ Please contact me with the charge amount and to arrange payment.

☐ I am requesting these records be provided without charge because they are requested for purposes relating to a claim or appeal under a provision of the Social Security Act. Documentation of the claim or appeal is attached.

Signed:__________________________________________     Date:________________________________________

Print Name:______________________________________     Relationship to patient:_________________________