Request for Access to Patient's Health Information

As a patient of Michele T. Sasmor, M.D., you are entitled under federal law to access your personal protected health information. In order to process your request for access to this information, please complete this form and submit it to our office. If you have any questions or concerns, please contact the Privacy Officer, Kay at 978-462-8300.

Patient Information

Patient Name: _____ Birth Date: _____

Access Method

You have the right to view your protected health information, obtain a copy of the information, or both. Please indicate below whether you wish to view the information only, obtain a copy, or both. If you select copy, please indicate your method of delivery.

[ ] I would like Dr. Michele Sasmor to obtain medical record/lab results to assist with my treatment from the following:

Name _____ Street _____
City _____ State _____ Zip _____

Release type:
(check what applies)

( ) All Medical Records _____ ( ) Lab Results _____
( ) X-Ray Results _____ ( ) Other _____

[ ] I would like to **view** my protected health information. I have/will schedule(d) an appointment with Michele T. Sasmor, M.D. to view my health information on _____. I understand Michele T. Sasmor, M.D. may have a staff member sit down with me as I review my health information.

[ ] I would like a **copy** of my protected health information. I understand that Michele T. Sasmor, M.D. may charge me a fee of .15c per page for the copy. I am also aware that I am required to pay the fee in full before I can obtain the copy.

[ ] I will return to Dr. Sasmor's Office and pick up the copy when it is ready.

[ ] I would like Dr. Sasmor's Office to send a copy of my record to the following:
_____
_____
I understand that Dr. Sasmor's Office may charge me all applicable postage fees.

[ ] I would like Dr. Sasmor's Office to send the copy via facsimile to the following number: _____. I understand that Dr. Sasmor's Office may charge me a fee of .15c per faxed page.

By signing below, I acknowledge and agree to the above conditions.

_____
Signature of Patient

_____
Date

FOR OFFICE USE ONLY

Request received on _____ by _____
Request reviewed and processed by _____ Date _____