REQUEST FOR ACCESS TO PATIENT'S HEALTH INFORMATION

As a patient of Downtown Performance Medical Center, you are entitled under federal law to access your personal protected healthcare information maintained in a "designated record set." In order to process your request for access to this information, please complete this form and submit it to the privacy officer. When received by the privacy officer, he/she will use the information to verify your identity and process your request. If you have any questions or concerns, please contact the privacy officer, Juanita S. at (713) 652-0011.

Patient Information:

Patient Name: ____

Birth Date: ____

Patient SS#: ____

Date of access request: _____/_____/_____

Access Method

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

[] I would like to view my protected healthcare information. I will/have schedule (d) an appointment with Downtown Performance Medical Center, INC. to view my healthcare information on _____/_____/_____. I understand Downtown Performance Medical Center, INC. may have a staff member sit down with me as I review my healthcare information.

[] I would like a copy of my protected healthcare information. I understand that Downtown Performance Medical Center, INC. may charge me a fee for copies as set forth in the following schedule: $15.00 for research and retrieval, $1.00 per first 50 pages, and $.50 per page for each additional page. I also understand that I may be required to pay the fee in full before I can obtain a copy. I have selected my delivery method below (if none is selected, I will pick up the copy at the practice):

[] I will return to Downtown Performance Medical Center, INC. and pick up the copy when it is ready.

[] I would like Downtown Performance Medical Center, INC. to send the copy via U.S. Mail to the following address: ____

I understand that Downtown Performance Medical Center, INC. may charge me all applicable postage fees.

[] I would like Downtown Performance Medical Center, INC. to send the copy via facsimile to the following number: (____) ____-______. I understand the Downtown Performance Medical Center, INC. may charge me a fee of $1.00 per faxed page.

[] I would like Downtown Performance Medical Center, INC. to provide to me an explanation or summary of the information provided. I understand that Downtown Performance Medical Center, INC. may charge me a fee of $50.00 for the explanation or summary, and I may be required to pay the fee in full before I can obtain the explanation or summary.

I understand the Downtown Performance Medical Center, INC. is given thirty days to process my request for access if

my information is maintained on-site, sixty days if the information is maintained off-site, and that Downtown Performance Medical Center, INC. may extend the deadline by an additional thirty days if I am notified in writing of the extension. If further understand that my rights are limited to any information in my "designated record set" as defined in section 164.501 of the Code of Federal Regulations.

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

Print Full Name:____

_______________________________________ _______________
Signature of Patient Date