

FAMILY PHYSICIANS OF O'FALLON, P.C.
ACCESS REQUEST FORM

Patient's Name:			
	Last	First	Middle
Home Address:			
Home Phone:		Date of Birth:	

I am requesting the above records for the purpose of (i.e. Specialist Visit, Personal Use, Transfer to a new Provider, etc.) _____

I hereby request that the Practice provide me with **[please check all boxes that apply]**

- My medical records. (see fees on back)
- My billing records.
- The attached FMLA, disability, accident or other **FORM** (see fees on back)
- Specific Information (Define) _____

Please check one of the following boxes:

- I am only interested in accessing or obtaining a copy of the Requested Information for the following time period (From)_____ (To)_____.
- All available.

I understand that any information provided to me pursuant to this request will not include psychotherapy notes, information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be required by applicable law.

I understand that the Practice may deny this request under limited circumstances permitted by federal and state law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by the Practice who did not participate in the Practice's decision to deny my request.

I understand that the Practice will notify me of its decision to approve or deny my request to access or obtain a copy of the Requested Information within thirty (30) days of receiving this request if the information is maintained or accessible on-site at the Practice or within sixty (60) days if the Requested Information is not maintained or accessible on-site at the Practice. If the Practice is unable to comply with my approved request for information maintained or accessible on-site within thirty (30) days, it may extend the applicable deadline for up to thirty (30) more days by notifying me in writing. The practice will provide the Requested Information to me in paper form

I would prefer to:

Pick-up the Requested Information. We will call when your records are available.

Have the Requested Information mailed to me at the following address:

If I am granted access to the Requested Information, **I would** **I would not** like the Practice to provide me with an explanation of such Requested Information. **[Please check the appropriate box]** Due to the private and sometimes technical nature of this information a nurse will upon request establish a mutually acceptable appointment time to discuss the information. The additional cost for this service is \$50.00 for a 30-minute consultation.

X _____
Signature of Patient (or Personal Representative)

Date

Printed name of Personal Representative

Relationship to Patient

* * * * *

I understand that the Practice will charge me duplication fees as follows: ninety-two **(92) cents per page for the first through twenty-fifth (25th)** pages, sixty-one **(61) cents per page for the twenty-sixth (26th) through fiftieth (50th)** pages and thirty-one **(31) cents per page for all pages in excess of fifty (50)**. All FORMS requested to be completed by our staff will be assessed a **\$10 per page** fee.

For any copies made from microfiche or microfilm, the charge shall not exceed \$1.53 per page. These rates shall be automatically adjusted as set forth in Section 8-2006 of the Illinois Code of Civil Procedure (i.e., based on changes in the CPI). For duplication of record material or information that cannot routinely be copied or duplicated on a standard commercial photocopy machine such as x-ray films or pictures, the Practice may charge for the reasonable cost of such duplication, as well as \$25.00 per hour for clerical work necessary to complete my request, and any applicable mailing fees.

I understand the fees associated with my request and agree to remit payment at the time of receipt: I further understand that I may request my medical records as a lower cost alternative to having my FORM completed, and processing time will be between 2-4 weeks.

X _____
Signature of Patient (or Personal Representative)

Date

After you have completed this form please return it to the Privacy Officer or Practice Manager by mail at the following address: **Privacy Officer/Practice Manager, Family Physicians of O'Fallon, P.C., 310 N. Seven Hills Rd, O'Fallon, IL 62269.**