The Country Doctor's Authorization to Access Medical and Billing Records

Patient Name: _____

Patient Address:_____

Patient Phone _____ Patient Date of Birth _____

I hereby request that the Practice provide me with a copy of the listed information

___My medical records.
___My billing records.

Please check one of the following boxes:

___I am interested in accessing or obtaining a copy of the listed information from the following dates _____ to _____ .

___I am interested in accessing or obtaining a copy of the checked items above for all dates.

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 at a mutually agreeable time and place

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

_____

_____

_____

I have read and understand the terms of this records access document.

_____ _____ _____
Patient or guardian's signature Date Witness