PATIENT REQUEST FOR ACCESS TO HEALTH INFORMATION

Patient Information: As a patient of Trenton Medical Center, Inc. (Trenton Medical Center, Trenton Pediatrics, Bell Family HealthCare and Bell Pharmacy) you are entitled under federal law to access your personal protected health 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 a Patient Advocate. When received by the Patient Advocate, he or she will use the information to verify your identity and process your request. I you have any questions or concerns; please contact Mary Allen at (352) 463-4516. ***I understand that Trenton Medical Center, Inc. will charge me all applicable fees.***

Patient Name: _____ Birth Date: _____

Patient Address: _____ Telephone No: _____

Social Security #: _____ Date of Request: _____

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 to **VIEW** my protected health information. I have/will schedule (d) an appointment with Trenton Medical Center, Inc. to view my health information on _____. I understand Trenton Medical Center, Inc. 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 Trenton Medical Center, Inc. may charge me a fee for the copies as set forth in the following schedule: $1.00 per page for the first 25 pages, and $0.50 per page for each additional page. I also understand that I may be required to pay the fee in full before I can obtain the 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 Trenton Medical Center Inc, and pick up the copy when it is ready.

[ ] I would like Trenton Medical Center, Inc. to send the copy via U.S. Mail to the following address_____

_____

[ ] I would like Trenton Medical Center, Inc. to send the copy via facsimile to the following number: _____.
I understand that Trenton Medical Center, Inc. may charge me a fee of $1.00 per faxed page.

[ ] I would like a SUMMARY or an explanation of the information provided. I understand that Trenton Medical Center, Inc. may charge me a fee between $50 to $150 depending on the complexity of my medical history 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 that Trenton 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 Trenton Medical Center, Inc. may extend the deadline by additional thirty days if I am notified in writing of the extension. I 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.

Signature of Patient Date