SCRI
Oncology Partners

Health Information Access Request Form

CancerCareSCRI.com

You have the right to inspect and copy your health information, which is kept in a designated record set, because it may be used to make decisions about your health care. Usually, this includes medical and billing records. We may deny your request to inspect and copy in certain very limited circumstances.

Please indicate, specifically, the information to which you are requesting access:

____

____

Please indicate the form or format in which you would like to receive your requested information:

____

____

Please indicate the means by which you wish to inspect or obtain a copy of the requested information (fax, mail, on-site, etc.), and provide the necessary phone number or address:

____

____

We may impose a fee of $__________ to cover the cost of copying the requested information or postage when you have requested a copy of the information be mailed to you.

Do you agree to these fees? _____ YES _____ NO

____ __________________________

Patient Name Patient Account Number

____ __________________________

Signature Date

____

Name of Personal Representative (if appropriate)

____

Signature of Personal Representative (if appropriate)

For (Practice Name) Use Only:

Date Received: ______________________________ _____ Accepted _____ Denied

If denied, check reason for denial:

_____ Excepted Information _____ Inmate Request _____ Confidentiality Issues

_____ Research _____ Privacy Laws _____ Other: ___________________

Date and method of informing individual of original decision: ______________________________________

____

If denied, was review requested? _____ Yes _____ No

Name of reviewing official: ______________________________ Decision on review:______________________

Date and method of informing individual of review decision: ____

Comments:____

____

____ __________________________

Staff Member Signature Date