Doctor's Choice HOME CARE, INC.
8010 25th Court E, Suite 103
Sarasota, FL 34243

Request for Access to Health Information

Name of Patient: _____ **Previous Name**: _____
Address: _____
_____
Date of Birth: _____

1. **I am requesting from Doctor's Choice Home Care ("DCHC") to:**
   - ☐ inspect
   - ☐ obtain a copy

   of the following health information that is maintained in a designated record set by DCHC:

Health Information	Date(s) of Service
☐ Complete home health medical record with Plan of Care/Orders	_____ to _____
☐ Hospital/SNF/Other Facility discharge records Treatment Notes	_____ to _____
☐ Billing/Invoice	_____ to _____
☐ Other health information: (specify)_____	_____ to _____

2. **I am requesting that DCHC send a copy of my records in the following format. I understand that DCHC will provide access to my records in the form and format that I request only if DCHC determines that it is readily producible in such form or format.**

   - ☐ Paper. If the preferred format is not readily producible, the access will be provided in a readable hard copy form or other such agreed upon form.
   - ☐ Electronic. If the preferred electronic format is not available in a readily producible by DCHC, DCHC will make the information available in an agreed upon alternative, readable electronic format.
     - ☐ Word
     - ☐ PDF
     - ☐ Excel
     - ☐ Other (USB, CD, Other): _____

3. **I am requesting DCHC to send my records in the following manner. I understand that DCHC will use best efforts to deliver records in the manner that I request.**

   - ☐ Email (Encrypted): In an effort to protect your health information, our standard practice is to encrypt our email.
     Email Address: _____
   - ☐ US Mail:
     Mailing Address: _____
     _____
   - ☐ In-Person Pickup
   - ☐ Other (please specify): _____

4. I am requesting that my records (in the above indicated format) be sent to the following individual:

Name: _____

Address: _____

Phone: _____

Email address: _____

(Only if requesting records to be sent via email)

I hereby request **DCHC** to provide me with access to my health information that DCHC holds about me in the DCHC designated record set in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I understand that DCHC has 30 days to respond to this request and that DCHC may extend this 30-day response period for another 30 days if, within the initial 30-day period, DCHC provides me with a written statement of the reasons for the delay and the date by which it will respond. I understand that in certain circumstances DCHC may deny my request.

I also understand that DCHC may charge a reasonable fee associated with copying (including the cost of supplies and labor), postage (if you want the records mailed to you), and, if requested, for preparing a summary or explanation of any records. These fees are described in the Schedule of Charges attached to this form.

By signing below, I acknowledge that I have read and understand this Request for Access to Health Information.

_____ _____

Signature of Patient/Legal Representative Date

_____ _____

Print Patient Name /Legal Representative Name Date

If signed by the patient's personal representative, explain authority to act on behalf of the patient:

_____

_____

Instructions for Directors

(INTERNAL USE ONLY)

1) Number of pages released: _____
2) Staff initials: ____
3) Verification of Identify of Patient Personal Representative requesting access
4) Person(s) Authorizing RELEASE:

   a. Name: _____

   b. Signature: _____ Date: _____

Submit to Compliance Department for notification of records released to patient, any non-patient generated record request should come through Medical Record Request SOP process

Schedule of Charges

Description	Quantity	Rate
First Twenty-Five pages Printed	Max 25	1.00/page
Any additional pages printed in excess of the initial 25	Pages 26 +	25 cents/page
CD/DVD	Each	5.00 per disc
Postage	Each Individual	Standard rates apply
Email	No Cap/no max	No Charge