

Completion Date: _____

Attachment 19

Effective Date: April 14, 2003

Request for Access to Health Information

As a patient of a University of Miami provider or hospital, you may access certain health information we maintain about you. If you want to inspect and/or receive a copy of your health information, you must complete this form and return it to a Document/Records Custodian or to the University of Miami Privacy Office, at the addresses specified in our Notice of Privacy Practices. This request applies only to the departments that you indicate below.

To assist us in locating your information, please provide the following:

Date of Request: _____

Patient Name: _____

Date of Birth: _____

Soc. Sec. Number: _____

Phone Number: _____

Medical Record Number: _____

IDX SMS

Address: _____

I am requesting access to my health information maintained at:

Department _____

Physician _____

Facility/Hospital _____

Please indicate whether you would like to inspect or receive a copy of your health information by checking the applicable box(es):

I would like to inspect my health information in person at the University of Miami.

I would like a copy of my health information.

Please indicate, by checking the appropriate box(es), the specific information to which you want access:

Medical records (i.e. lab reports, films, etc.) for the following dates _____.

Billing records (i.e. claims or statements) for the following dates _____.

We charge fees for copies, postage and handling, as permitted by applicable state and federal law. You will be contacted with a total and instructed how to make payment as well as when you can expect to receive your records (if you have requested a copy).

Signature of patient or personal representative

Date

If personal representative, authority to act on behalf of patient/Relationship to Patient

University of Miami Privacy Office
PO BOX 019132 (M-879)
MIAMI, FL 33101

privacy@med.miami.edu
(305) 243-5000

Request for Access to Health Information

Form
D3900018E

Revised
05/21/03



NAME: _____

MRN: _____ IDX SMS

SS: _____

AGE: _____ DOB: ____/____/____

DATE OF SERVICE: ____/____/____