

ATLANTIC ORTHOPAEDICS, P.A.
REQUEST TO INSPECT OR COPY PROTECTED INFORMATION

This form is being used by the patient to request an opportunity to examine or copy protected health information in the possession of the practice known as **ATLANTIC ORTHOPAEDICS, P.A.**

INFORMATION REQUESTED:

Please describe the information that you would like to examine or obtain a copy of:

REVIEW OF PROCEDURE:

Your request to inspect or obtain a copy of your protected health information will be reviewed by our Privacy Officer. The Officer will determine if the information requested can be made available to you. We may legally be prohibited from making certain information available to patients or patient representatives, including:

- Psychotherapy notes
- Information related to legal proceedings
- Information that federal or state laws prevent us from disclosing
- Information that is related to medical research in which you agreed to participate
- Information whose disclosure may result in harm or injury to you or another person
- Information that was obtained under a promise of confidentiality

Within the limitation of the law, we will make every effort to accommodate your request.

We will complete our review of your request and either arrange for you to inspect your records within 30 days (60 days if records are off site) or provide you with a written explanation of any restriction on the information that we can provide you.

If we deny your request, in whole or in part, you may request that we review the decision.

This practice reserves the right to charge _____ for retrieval and preparation and copying of these records in accordance with Section 164.524 of the HIPAA ruling. This fee has been set and is considered reasonable, allowing every patient to have the ability to request access to their information.

Name of Patient (Please Print)

Signature of Patient

Date

Signature of Patient Representative

Date

Relationship of Representative to Patient

Patient Date of Birth