



MRN: _____

PCP: _____

Medical Records Release

REQUESTING ACCESS TO OR COPIES OF MEDICAL RECORDS ON FILE AT ECIM

Purpose for request: Changing Provider Insurance VA other: _____

Request for: Progress Notes Labs X-ray reports History & Physical

Immunizations Records for the last two years

Other: _____

Record dates: ____/____/____ to ____/____/____

Contact#: _____ **Requested Pick-Up Date:** ____/____/____

I, _____, request access to my medical records for my personal inspection or by _____, my personal representative, on _____ at _____.

Date Time

Practice Response to Request (Must be within 60 days of receipt of request)

___ Grants all or part of your request _____

___ Denies all or part of your request _____

Denial for the following reason:

- Not part of your designated record set
- Contains psychotherapy notes
- Subject to CLIA
- Information was compiled for civil, criminal or administrative actions (See Notice of Privacy Practices)
- Regards an inmate at a correctional institution
- Record was created during research
- Is subject to Federal Privacy Act
- Was not created by this practice
- Denied at the discretion of ECIM as the information may be harmful to the patient or a third party.

___ ECIM requests a 30 day extension to respond due to _____.

----- **OR** -----

I, _____, request ECIM make copies of my medical records for my personal inspection. I understand that these records contain "Protected Health Information" (PHI). I agree to be responsible for the cost of copying these records, including copying fees, labor, supplies and postage (if applicable). The charge for this will be \$0.50 per page and I will be charged a minimum of \$10.00. I agree to pay for this prior to service being rendered.

Patient's Signature: _____ Date of Request ____/____/____

Printed Name of Patient: _____ Date of Birth ____/____/____