RIGHT OF ACCESS REQUEST

This form is intended to comply with an individual's right under HIPAA to access his/her health information (45 CFR 164.524) and with the Health Information Technology for Economic and Clinical Health Act (HITECH) 42 U.S.C.A 17935. REMINDER: This form is only necessary when the patient requests that his/her protected health information (PHI) be forwarded to a 3rd party.

Please fully complete this form and sign and date at the bottom.

Information about the medical provider and dates of service:

Name of the Doctors Group:

Specific Account Number(s):

OR, Specific Date Range: **FROM:** **TO:**

Information about you, the patient:

Name (as provided at the hospital):

Home Address:

City / State / Zip:

Date of Birth: Last four digits of SSN:

Information about the 3rd party:

Name of Entity:

Mailing Address:

City / State / Zip:

E-mail Address:

Format of the billing records (electronic or paper copy):

How and in what format do you want the billing forwarded (choose one):

PDF file forwarded by secure e-mail message to the 3rd party's e-mail address listed above	
Paper record(s) forwarded by U.S. mail to the 3rd party's address listed above	

Instructions, fee and address:

The fee is $6.50 payable to the applicable ER physicians group.

Mail the completed / signed form and payment to:

MEDISERV HITECH REQUESTS / P.O. Box 25144 / Fort Worth, TX 76124.

Or, the completed / signed request form may be e-mailed to us at **sendmyrecords@mediservltd.com.**

Please note that we will not consider the request complete until we receive payment of the $6.50 fee.

We will act on the request within 30 days of receiving thepaperwork and payment in our office.

Please sign and date below:

Name of Patient (Please Print)

Signature of Patient **Date Signed**