NORTH BUNCOMBE FAMILY MEDICINE, PA

Patient Request for Access to Medical Record

Patient Name: _____

Date of Birth: _____

Patient Chart Number: _____

Date of access request: _____

Choose one of the following:

[ ] I would like to view my medical record. I have/will schedule(d) an appointment to view my health information on _____. I understand that North Buncombe Family Medicine, P.A. may have a staff member sit down with me as I review my health information.

[ ] I would like a copy of my medical record. I understand that I may be charged a fee for the copies. I understand that I may be required to pay the fee in full before I can obtain the copy.

Purpose and Description of information to be released:

_____

Please indicate how you would like your copies delivered. (pick-up, mail, fax, etc.)

_____

***For pick-up, please indicate the person that is authorized to pick-up the records.**

I understand that North Buncombe Family Medicine, P.A. is given thirty (30) days to process my request for access if my information is maintained on-site, sixty (60) days if the information is maintained off-site, and that North Buncombe Family Medicine, P.A. may extend the deadline by an additional thirty (30) days if I am notified in writing of the extension. I further understand that my rights are limited to any information in my "designated record set" as defined in the Code of Federal Regulations.

By signing below, I acknowledge and agree to the above conditions.

_____

Patient Signature

_____

Date

_____

Witness