Crouse
MEDICAL PRACTICE, PLLC

REQUEST FOR ACCESS TO HEALTH INFORMATION

Did You Know? You can access your records anytime on our Patient Portal!

Crouse Medical Practice (CMP) provides patients with a secure online website that gives you convenient 24 hour access to your personal health information and medical records, from anywhere there is internet connectivity. CMP encourages patients to use the Patient Portal for a more timely response, and to be able to download or print parts of your medical record including lab results, recent doctor visits, medications, and immunizations. Ask any of our staff how you can access the Patient Portal.

If you prefer to submit your request for access to our staff, or to request access to records not available on our portal, please complete and return the following request form. Only certain parts of this form are required, but completing all sections will help facilitate your request.

PATIENT INFORMATION (REQUIRED)

Patient Name:_____ DOB:____/____/_____
Last First MI

Address:_____

Telephone: (daytime): _____ (evening):_____

Health Care Provider Name: _____

ACCESS REQUESTED

Our patients and their personal representative have a right of access to inspect and obtain a copy of their health information maintained by CMP, for as long as we maintain the information. You may also request an explanation of complicated information.

What type of access are you requesting? ____INSPECT ____ COPY ____EXPLANATION

If your request to inspect the information is granted, we will provide you with further information on how to schedule an appointment with our staff to inspect your records.

What information would you like to access? If you can, please provide the dates that tests were performed or treatment was provided.

_____

_____

PERSON/ENTITY TO RECEIVE RECORDS (REQUIRED)

____ I will receive my own records.

____ I request that my records are provided to another person or entity. *Please specify below.*

Person/Entity to receive your records:_____

Address: _____

Phone:_____ Fax:_____

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If you are requesting a copy, summary, or explanation of the information, please specify format:

_____ Electronic Format *Select one:* _____ CD _____ Other *Please specify:*_____

_____ Paper

If you are requesting a copy, how would you like the copies provided and delivered?

_____ Pick up at CMP Office *Specify location:* ___ Irving Ave. Internal Med. Suite 200 ___ Irving Ave. Cardiology
___ Irving Ave. Internal Med. Suite 300 ___ Clay Cardiology
_____ Mail ___ Madison-Irving ENT ___ Brittonfield Cardiology
___ Irving Ave. Neurovascular/Neurosurgery ___ Neurology
___ Erie Boulevard ___ Manlius ___ Brittonfield Internal Medicine

FEES

We may charge you a reasonable fee to recover the costs of copying and materials. **For copies provided in hard copy or electronic copy, we charge a flat fee of $6.50.** Note: For hard copies sent via US mail, we may charge an additional fee if postage costs are significantly high or out of the ordinary. We will notify you in advance if this additional fee is necessary.

UNDERSTANDING AND SIGNATURE (REQUIRED)

By signing below, I am requesting that CMP provide me with access to my health information in the manner described above. I understand that I may be expected to pay the fees.

_____ _____
Signature of Patient or Personal Representative Print Name of Patient or Personal Representative

_____ _____
Description of Personal Representative's Authority Date

Completed forms may be dropped off at any CMP location, faxed, or mailed. For a list of CMP addresses and fax numbers, go to crousemed.com/locations

For Internal Use Only:
Date Received: _____ /_____ /_____
Disposition of Request: ____ GRANTED ____ DENIED ____ PARTIALLY DENIED
Patient Notified In Writing of Response to Request on This Date: ____/____/____
Date records mailed or provided: _____ /_____ /_____
Fee charged for fulfilling this request (if applicable): $ _____
Name of staff processing this request: _____
Provider Reviewed: _____