MAYFIELD

# Patient Request to Access Medical Record for Inspection and/or Copying

With some exceptions, you have the right of access to obtain a copy or inspect your medical record held by Mayfield Clinic. Your medical record includes any item, collection or grouping of information that includes protected health information related to care and treatment or billing and is maintained by or for Mayfield Clinic. We are not always required to grant such access but each request will be carefully reviewed and approved if warranted. We will strive to notify you within 30 - 60 days whether your request has been approved or denied and the reasons for any denial.

Last Name _____ First _____ Init. _____

Maiden _____ Address_____

City_____ State_____ Zip_____ Telephone (_____) _____-_____

SS# _____-_____-_____ DOB ____/____/____

Please indicate the medical information you wish to review:

Information from (date) ____/____/____ to ____/____/____ as indicated below:

- ☐ Office Visit Notes
- ☐ Consultation Reports
- ☐ Priority Consult History and Documents
- ☐ Testing Results
- ☐ Hospital Records
- ☐ Entire Chart
- ☐ Billing Records

☐ Radiographic films _____ Date ____/____/____

☐ Other _____

I wish to: (check box that applies)

- ☐ Receive a copy by mail of the information listed above.
- ☐ Come in and inspect the information listed above.
- ☐ Come in and inspect the information listed above and pick up a copy at the same time.

*Note that if you request to receive a copy of the information, we may charge you a reasonable fee for preparation, copying and postage as allowed by state law.*

Patient/Legal Representative Signature* _____

*Describe scope of authority to act for patient _____

Date (Must be no more than 60 days prior to submission) ____/____/____

Received By _____ Date Received ____/____/____

Medical Record #_____ Sent to _____

Date Sent ____/____/____

*Mail completed form to: Mayfield Clinic, Attn: Medical Records, 3825 Edwards Road, Suite 300, Cincinnati, OH 45209.*