



REQUEST TO ACCESS MEDICAL OR BILLING RECORDS
INFORMATION AND INSTRUCTIONS

You may tear off this page and retain it for your records.

The attached form may be used to request access to your medical records. We are required to allow you to access your health information unless federal law specifically permits denial.

Submitting a Request for Access

For more information about accessing a medical or billing record, you may contact our Privacy Officer at 828-757-5566 or Contact Officer at 828-757-5177. Note, however, that requests for access must be made in writing and will not be accepted by the Privacy Officer or Contact Officer/Office at this number.

To submit a Request for Access please complete, sign and return the attached for to:

Privacy Officer
c/o Administration
Caldwell Memorial Hospital
P.O. Box 1890
Lenoir, NC 28645

Timeframe

1. On-Site Records – If the records are stored on-site, we should respond to your request within 30 days of our receipt of your request.
2. Off-Site Records – If the records are stored off-site, we should respond to your request within 60 days of receipt of your request.
3. Other Delay – If it takes longer than 60 days to respond to your request, we will provide notification of the delay to you and respond to your request within 90 days of receipt of your request.

Costs

There will be a charge for the costs associated with shipping your records. You will be notified and billed for these costs prior to shipping. The following fees will be charged for providing physical copies of medical records to you:

Research and Retrieval	\$	5.00	
Per Page Copy / Scan		0.10	Per page
Diskette / CD		1.00	Per disk or CD for scanned records
Shipping			Cost of shipping method to be provided



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Patient Name _____ SSN# _____ DOB _____

Phone # (H) _____ (W) _____

Describe the information that you would like to access _____

Please check the method of access that you desire:

___ On-site review. Circle Preference: AM PM MON TUE WED THU FRI

___ Physical copies. Circle Preference: Paper 3 1/2" Floppy Disk CD-ROM

___ Summary. If you are requesting your entire medical record, or the record of a course of treatment (i.e., the records related to cancer treatment), we will provide a summary of those records in lieu of the records themselves, at your request. There will be a charge for the costs associated with preparing the summary. You will be informed of, and billed for, these charges prior to shipping.

___ I will pick up the records. Please notify me when they are available.

___ Please ship my records to:

Select one or more methods: (circle one) US Mail Certified Registered Overnight Delivery

If you are not the patient, please fill in the following:

Name: _____

Relationship to the patient: _____

Address (if different than above): _____

Phone # (if different than above): (H) _____ (W) _____

Signature _____ Date _____

**Please provide a copy of your driver's license
or other form of identification with this request.**