Allergy Treatment Center of New Jersey, PC

REQUEST FOR COPY OF PROTECTED HEALTH INFORMATION

Please Print

Patient Name: _____ Date: _____

Patient Address _____
_____
_____

I request a copy of my protected health information. I want a copy of (please choose one):

_____ My entire medical record
_____ A summary of my entire medical record
_____ Only that part of my medical record that relates to:
_____
_____
_____ A summary of that part of my medical record referenced above

We will provide you with access to your protected health information in the form or format you request, if it is readily producible in such form or format.

We will charge a fee for the copy you requested. Our fee is governed by law, New Jersey Administrative Code §13:35G-6.5(c)(4), and is $1.00 per page, up to $100.00, with a $10.00 minimum fee. If you have requested a summary of your record, we will advise you, in advance, of the fee for the summary.

_____
Signature of Patient or *Personal Representative*

_____
Date

NOTE: Under law, there are certain cases where we cannot release some of your protected health information for copying. We will advise you in writing if this occurs in your case, and of your rights.

FOR PRACTICE USE ONLY:

Date copy request received:_____
Date copy provided: _____
Date of denial of full copy requested: _____

_____
Signature of Privacy Officer

_____
Date

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1100 Centennial Avenue Suite 202 Piscataway, NJ 08854 *fax:* 732.562.1770 *tel:* 732.562.1717
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