EXHIBIT P

REQUEST FOR ACCESS TO MEDICAL INFORMATION

Our Notice of Privacy Practices contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect, and copy protected health care information used to make decisions about them.

The Practice will only include information used to make decisions about the patient. The Practice may limit access to information generated only by this Practice. Under some circumstances, such as increased risk of harm or injury, the Practice may withhold the requested information. The Practice will generally provide the information requested or otherwise respond within thirty (30) days, or within sixty (60) days if the information requested is offsite.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Name:_____

Health Care Information requested. Please provide dates, diagnosis, treatment, or any other indications of the specific information you desire:_____

_____

_____

Do you wish to:

- ☐ Arrange an appointment to inspect the requested information? _____
- ☐ Receive a copy of the information? (The copying charges per the attached schedule will apply.)

Instructions regarding copies.

- ☐ I will pick the copies
- ☐ Please mail the copies to me at the following address:_____

_____

(I understand that I will need to pay applicable copying charges and postage before the records are mailed.)

This Request was signed by: _____

Printed Name – Patient or Representative

Date:_____/ /___

Representative's Authority to Sign for Patient): _____
(e.g. parent, guardian, legal representative)