ATTACHMENT A
Patient's Request for Access to, and to Obtain a Copy Of, Their Protected Health Information
(Please read carefully)

Patient:

I ________________________________request access to my protected health information contained in the medical records or billing records maintained by LSUHSC-NO to review the contents and obtain copies.

Or:

Patient's Personal Representative:

I ____request access to the protected health information of

____ contained in the medical records or billing records maintained by LSUHSC-NO to review the contents and obtain copies.

I have the right to inspect and request copies of whatever portions or the entirety of the health records as well as to request a summary explanation of these records. I understand this request will require the collection of these records and that LSUHSC-NO will arrange a convenient time and place for me to conduct my review of this protected health information. I request access and/or copies/summaries of the following information:

From: (date) ____/____/________ To: (date) ____/____/________

Please check type of information to be accessed/copied:
__Complete health record ___Diagnosis & treatment codes___ Discharge summary
__History and physical exam ___Consultation reports ___ Progress notes
__Laboratory test results ___X-ray reports ___ X-ray films / images
__Photographs, videotapes ___Complete billing record ___ Itemized bill
__Other, (specify) ____

I would like the above information provided in the following format: ____________________________________

I would like this information provided to me by the following method (check one):
____Personal pick-up
____US Postal Service to:

(Address)____

____

Other (specify) ____

Signature_______________________________________

Date: ____/____/________