SIRUCEK CHIROPRACTIC NEUROLOGY CLINIC

Request for Patient Access to Health Information

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I hereby request access to health information for:

_____
_____.
(Print Patient's name and address)
If known: Year of birth: _____

SCOPE OF ACCESS REQUESTED
I would like access to: ⌐ All the records or ⌐ The portion of the records concerning:

(specify type of disease, accident, dates of treatment, or other portion of records you are interested in.)

TYPES OF ACCESS REQUESTED
Inspection. Please let me know when I may come to inspect the records (, and the amount of the charge if any).* I understand that an employee of the medical practice may be present and that I may not make any marks or alter the records in any way.

Copies. I would like copies of ⌐ All records requested *or* ⌐ All records other than X-rays or tracings / copies of X-rays only

Transfer. Please transfer ⌐ Copies of health records requested *or* ⌐ X-ray copies only.

To:
(Name and address of health care provider to whom the records are to be delivered)
I would like the information in the following form or format if it is readily producible in the form: _____.

Signed: _____ Date:_____

If not signed by the patient, please indicate relationship:
- parent or guardian or minor patient (to the extent minor could not have consented to the care)
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient