

ATTACHMENT A

**Patient's Request for Access to and to Obtain a Copy
of Their Protected Health**

(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:

- | | | |
|--|--|---|
| <input type="checkbox"/> Complete health record | <input type="checkbox"/> Diagnosis & treatment codes | <input type="checkbox"/> Discharge summary |
| <input type="checkbox"/> History and physical exam | <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Progress notes |
| <input type="checkbox"/> Laboratory test results | <input type="checkbox"/> X-ray reports | <input type="checkbox"/> X-ray films / images |
| <input type="checkbox"/> Photographs, videotapes | <input type="checkbox"/> Complete billing record | <input type="checkbox"/> Itemized bill |
| <input type="checkbox"/> Other, (specify) _____ | | |

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: _____