SUMMIT ORTHOPEDICS

SUMMIT PATIENT ACCESS REQUEST FORM

I understand that as a patient of Summit Orthopedics, Ltd. (Summit), I have the right under the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) to access my Protected Health Information (PHI) in a Designated Record Set[1] and to access my Health Records[2] under the Minnesota Health Records Act (MHRA) (collectively, "Health Information" for purposes of this form).

If I am initiating the Health Information access request, I generally need to use this *Access Request Form*.[3] If I am being asked to provide authorization for a third party to obtain access to my Health Information, I will generally need to use the *Patient Authorization Form*. Attached to this form is the *Patient Access Request Form and Patient Authorization Form Chart*. Refer to that chart for information regarding use of this form and the procedures that apply. For additional details, see the *Summit HIPAA Privacy Patient Access Request Policy and Procedure*, also attached.

I understand that I have the right to **both** obtain copies of Health Information and inspect (read through) my Health Information. I can choose to: (a) only request a copy of my Health Information; (b) only read my Health Information onsite at Summit; or (c) do both. I understand that I am not required to come on site at Summit to read through my Health Information. For example, I can request that a copy of the documents be mailed to me and read through them at home at my convenience.

Type of Access Request. Check those that apply to the access request that you are making:

☐ I request that a copy of my requested Health Information be provided to me. My name and address are provided on p.2 of this form.

☐ I request that a copy of my requested Health Information be provided to a third person, whose name and address are provided on p.2 of this form.

☐ I request that my requested Health Information be sent to me or the third person **by unencrypted/unsecure email.** (NOTE: Sending the Health Information by unencrypted/unsecure email may result in interception in transmission or receipt by someone who is not authorized to have access to your Health Information, which could result in identity theft or other harm. By checking this box and requesting that your Health Information be sent this way, you are assuming the risk of unsecure transmission and receipt. Summit is not responsible for unauthorized access and is not required to report any breach with respect to this transmission.)

☐ Instead of or in addition to obtaining a copy of my Health Information, I want to inspect (read) my Health Information on the Summit premises. I understand that I can only come onsite to read my Health Information during regular office hours for that location. For outreach locations, the office is only open periodically (*e.g.*, once per week). Summit will contact you to determine a date, time and location convenient for you.

Regardless of which of the four boxes you check above, you must also complete the remaining sections of this form on page 2.

[1] A "Designated Record Set" is a group of records maintained by or for Summit Orthopedics (Summit) including medical records; billing records and health insurance coverage and payment or any records used by or for Summit to make decisions about the Patient. The term "record" means any item, collection, or grouping of information that includes PHI that is maintained, collected, used, or disseminated by or for the Plan.

[2] "Health Records" means any information that relates to the past, present or future: (a) physical or mental health or condition of the Patient, (b) provision of care to the Patient or (c) payment for care to the Patient.

[3] There are a few circumstances where you may be required to complete a Patient Authorization Form even when you are initiating the request (such as when you are requesting access to information that is not a part of a Designated Record Set or when you are requesting that Health information be provided to your employer).

SUMMIT PATIENT ACCESS REQUEST FORM

PATIENT INFORMATION:	Patient Full Name (print):	DOB:
	Address (City, State, and Zip Code):	
	Phone Number:	Email Address:

HEALTH INFORMATION RELEASED FROM:	☐ Summit Orthopedics, LTD. 710 Commerce Dr. #200, Woodbury, MN 55125	Phone: 651–968–5125 Fax: 651–968–5907

HEALTH INFORMATION RELEASED TO:	☐ Name of Organization/Clinic: **–OR–** ☐ Self	Attn:
	Address (City, State, and Zip Code):	
	Phone Number:	Fax Number:
	E-mail address (if to be sent by email):	

HEALTH INFORMATION TO BE RELEASED:	☐ Specific Date/Year of Treatment_____ ☐ CD of Images ☐ Doctor Notes ☐ Therapy Notes ☐ Operative Report ☐ Injection Notes ☐ Lab Reports ☐ Radiology Reports ☐ EMG Report ☐ Billing Statement ☐ Other_____ **The Following Requires Special Consent by Law and must specifically be requested in order for it to be released:** ☐ Chemical Dependence Program ☐ Psychotherapy Notes
DELIVERY METHOD:	☐ U.S. Mail to the person and at the address indicated in the "Health Information Released To" section above ☐ Email to the address indicated in the "Health Information Released To" section above ☐ Fax at the number indicated in the "Health Information Released To" section above ☐ CD of Images (required for images and will be sent by US Mail) ☐ In-person pick up at the Summit office location noted here:_____

_____ _____ _____

Print Name Signature Date

Personal Representative's authority to sign (proof required): ☐ Patient is a Minor ☐ Power of Attorney or Legal Representative ☐ Other_____

Summit Orthopedics, Ltd. Includes its clinics, surgery centers, diagnostic imaging centers, recovery suites, bracing and orthotics, the components of Minnesota Occupational Health that are subject to HIPAA, and the Woodbury Ambulatory Surgery Center, LLC.

Released By:_____ Date:_____ MRN:_____ Physician:_____