Lake Podiatry, PA
144 Highland Street
Unit One
Plymouth, NH 03264

Patient's Request to Inspect and Copy Medical Record or other recorded Protected Health Information (PHI)

Patient Name: _____ Patient ID#: _____

Address: _____ Date of Birth: _____

City/State/Zip: _____ Home Phone: _____
Work Phone: _____

Pursuant to Privacy Rule 164.524 I hereby request a copy of my medical record or other recorded Protected Health Information (PHI). I understand that the practice has up to 30 days to comply with this request.

☐ Mail a copy of the records requested to me at the above address

☐ Mail a copy of the records requested to the following:

_____
_____
_____

☐ Release a copy of the records requested to my authorized representative:

_____

I agree to pay the reasonable cost of copying of **$**_____ per page for documents and **$**_____ per x-ray and the cost of mailing the aforementioned records. I agree to pay the total estimated costs for these services prior to mailing.

The total cost is estimated to be **$**_____

_____ _____
Signature of Patient or Legal Representative Date

FOR PRACTICE USE ONLY

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Action Taken: ☐ **Granted** ☐ **Denied**

Reason for Denial (*if applicable*)

☐ Access is likely to endanger the life or physical safety of the individual or another person
☐ Psychotherapy note
☐ The information is compiled for use in a civil, criminal or administrative action or proceeding
☐ Other

Date Request Received _____ **Received By:** _____
Date Payment Received _____ **Received By:** _____
Date Request Fulfilled _____ **Fulfilled By:** _____