ORTHOPAEDIC ASSOCIATES OF SOUTHERN DELAWARE, P.A.

A Division of First State Orthopaedics, PA
12100 BLACK SWAN DRIVE, SUITE 201, LEWES, DELAWARE 19958
Phone: 302-644-3311 Fax: 302-644-3300

PATIENT OR PATIENT REPRESENTATIVE REQUEST TO INSPECT OR COPY PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

The Following Protected Health Information (PHI) is to be released: (patient or patient representative must check one box for each item):

Yes	No	Items Requested	Yes	No	Items Requested
☐	☐	Physician Notes	☐	☐	Drug/Alcohol Abuse
☐	☐	Lab Results	☐	☐	HIV Test Results
☐	☐	X-ray Reports	☐	☐	Mental Health Records
☐	☐	MRI Scans	☐	☐	OASD Claims/Billing Information
☐	☐	CT Scans	☐	☐	Complete Record generated by OASD to include Claims/Billing Information
☐	☐	EMG Reports	☐	☐	Complete Record generated by OASD do not include Claims/Billing Information
☐	☐	Bone Scans	☐	☐	Other: _____

_____

REVIEW OF PROCEDURES AND SELECTION OF INSPECTION OR COPYING OF MEDICAL RECORDS:

Your request to inspect or copy your PHI will be reviewed by the **Medical Records Clerk** of Orthopaedic Associates of Southern Delaware, P.A. (OASD) who will determine if the information requested can be made available to you. We may legally prohibit from making certain information available to patients or the patients' representatives, including: Psychotherapy Notes, information related to legal proceedings, information that federal or state laws prevent us from disclosing, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, and information that was obtained under a promise of confidentiality.

☐ **Inspection of Medical Records:** We will complete our review of your request and will arrange for you to inspect your records at our Lewes office within a **minimum of 14 business days** of your request.

☐ **Copying of Medical Records:** We will complete our review of your request and within the limitations of the law, we will make every effort to accommodate your request. If we **deny your request**, in whole or in part, you may request that we review that decision. It will take a **minimum of 14 business days** before your records will be copied. We will call you when your records are ready to be picked up at the Lewes office.

Indicate the reason why you want your medical records copied: _____

Provide full name and address if you want your records mailed to your doctor: _____

_____

I understand that my PHI may be redisclosed by the person or entity receiving my PHI from OASD, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI from OASD I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying OASD in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by OASD in reliance on this authorization before OASD receives my request for revocation or modification. I must sign and date my written request and send it to the following address: Medical Records Department, Orthopaedic Associates of Southern Delaware, P.A., 12100 Black Swan Drive, Suite 201, Lewes, Delaware 19958.

This authorization will expire on [date no more than one year in advance): _____

Signature of Patient or Patient Representative: _____Date: _____

If you are signing as the patient's representative, print your name: _____

Please indicate your relationship to the patient:
☐ Parent, guardian or caregiver of a minor patient
☐ Guardian or conservator of an incompetent patient.
☐ Beneficiary or personal representative of a deceased patient.
☐ Other: _____ (Specify Relationship)