# REQUEST TO ACCESS AND COPY MEDICAL RECORDS

Certified Mail # _____ or Hand Delivery (Date/Name) _____

To: _____ (HMO) To: _____ (Medical Group)

To: _____ (M.D. Name) To: _____ (M.D. Name)

To: _____ (Others)

## Patient Medical Records Request Statement

I am formally requesting access to all records in any form, including but not limited to, handwritten records, electronic records, and tape recordings produced by all the above-named parties and their agents within five (5) days of the receipt of this request. I am requesting copies of all records that I identify at the time of access.

## Patient Rights Statement

Patients have the legal right to participate in their healthcare. This includes the right to access and copy their medical records. Medical records are legal documents. Denial of access to and tampering with medical records are subject to legal action.

I am exercising my right to be fully informed of any transfer of my medical records (in any form) without my prior written consent. This includes, but is not limited to, transfer for purposes of healthcare operations/administration, research, employment, and inclusion in government/other databases, files, folders and/or other storage media.

## Patient Responsibility Statement

My HMO states that patients must accept responsibility for actively participating in medical decision-making. By taking responsibility, I require that my physicians and any other person/entity affecting my healthcare recognize and enforce my rights.

## Patient Satisfaction Request and Self-Protection Plan

Please contact me within **five (5) working days** of receipt of this request to arrange an appointment to access/copy my records at a convenient time and location, or specify all facts supporting non-compliance with my request. Should you be uncooperative in satisfactorily complying with my request, I will enforce my healthcare rights. Please include this document as part of my Official Medical Record.

| Patient Name (Print) | Agent Name (Print) | HMO Patient I.D. # |
|---|---|---|

| Patient Signature | or | Agent Signature | Date | ( ) Telephone # |
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Attachment: HMO or Medical Group Medical Records Access Form(s) (if available)