

# Prentke Romich

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## Patient Access to the Medical Record Request Form

I, \_\_\_\_\_, request access to my medical records for my personal inspection or by \_\_\_\_\_, my personal representative. (Please request date and time requested for record access)

Date \_\_\_\_\_ Time \_\_\_\_\_

**OR**

I, \_\_\_\_\_, request Prentke Romich Company to make copies of my medical records for my personal inspection. I understand that these records contain protected health information (PHI). I agree to be responsible for the cost of copying these records, including copying fees, labor, supplies, and postage (if applicable). The charge for this will be \$\_\_\_ per page and I will be charged a minimum of \$\_\_\_\_. I agree to pay for this prior to the service being rendered.

Patient Signature \_\_\_\_\_

Patient Printed Name and Date of Birth \_\_\_\_\_

Date of request \_\_\_\_\_

**PRC Response to Request** (Must be within 60 days of receipt of request.)

Grants all or part of your request \_\_\_\_\_

Denies all or part of your request \_\_\_\_\_

\_\_\_\_\_  
For the following reason: (Circle all that apply)

Not part of your designated record set; information was compiled for civil, criminal or administrative actions; regards inmate at correctional institution; is subject to Federal privacy act; was not created by PRC.