Herman Ostrow School Of Dentistry of **USC**

Chart Access Request form

Patient's Name: _____

Date of Birth: _____

Phone Number: _____

I hereby request that my University of Southern California health care Provider (s) provide me with the following information (check all that apply):

- ☐ My clinical records (e,g., medical records, dental record)
- ☐ My x-rays
- ☐ My billing records
- ☐ Other _____
  (Must be personally identifiable information used by USC to make clinical decisions about patient)

Please check the boxes that apply:

☐ I am only interested in accessing or obtaining a copy of requested information relating to the time period _____through_____.

☐ I am only interested in accessing or obtaining a copy of all requested information maintained by (please list the name of your health care provider (s) whose records you wish to access):

_____

_____

I agree to receive the Request Information in the form of summary prepared by USC at a cost to me of $ __6.50_____.

Information Accepted from Request:

I understand that any information provided to me pursuant to this request will not include information compiled in reasonable anticipation of (or for use a civil, criminal or administrative proceeding or as may otherwise be limited or restricted by applicable law. If further undeadening that I will not be provided access to records related to certain categories of treatment as required by law (for example, a minor 's receipt of contraception and /or family planning services.

Process if Request Denied

I understand that USC may deny this request under limited circumstances as provided for under federal and state law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by the USC who did not participate in the initial decision to deny my request.

I understand That USC will notify me of its decision to approve or deny my request to inspect the Request Information within five (5) working days of receiving the request and within fifteen (15) days after receiving this request if my request is for copies, unless I agree to additional time to respond. USC will provide me with a summary of Requested Information within ten (10) working days of receiving my request, or within a maximum of thirty (30) days if USC notifies me that more time is necessary, either because of the length of the record or because I was discharged from the hospital within the ten (10) day period to produce the summary.

Format for providing information:

I would prefer to (select one):

☐ Pick up or review the Requested Information at mutually agreeable time and place

☐ Have the Requested Information mailed to me at the following address

_____

_____

☐ Have the Requested Information mailed to:

_____

_____

☐ Have the Requested Information emailed to me at (**Disclaimer: email is not secured. You providing your email address is your consent for us to send via email**):

_____

I understand that USC will charge me $ ___6.50___ for the copying services necessary to complete my request, as well as any applicable mailing fees.

_____ _____

Signature of Patient (or Personal Representative) **Date**

_____ _____

Printed Name of Patient or Personal Representative **Date**

_____

Relationship of Personal Representative to Patient

_____

FOR OFFICE USE ONLY:

Records Copied _____ **Records Dispersed** _____

Fee Collected _____ **Completed By** _____