Edward T. Wolanski, M.D., P.C.

600 Peter Jefferson Pkwy, Suite 300 • Charlottesville, VA 22911-8837 • (434) 293-9800

Request for Access to Personal Health Information

Patient Name: _____ DOB: _____

Address: _____

City-State, Zip: _____

Home Phone _____ Work Phone: _____ Cell Phone: _____

I request to access to personal health information

___ I would like a copy of my health information – I understand I may be charged a reasonable cost based fee.

____ I would like to review my health information

____ I would like my health information to be provided to a third party:

Name of third party: _____

Please specify the records you wish to review or obtain copies of:

_____

_____

Select the format you would prefer:

___ Paper ___ Electronically Fax Number _____

___ Please mail to the above address ____ Flash Drive ____ Patient Portal

___Will pick up at the practice

___ Email: address :_____For

email communications, I understand that if the information is not sent in an encrypted there is a risk it could be accessed inappropriately. By providing my email address I elect to receive email communication as requested.

____ I would like a written summary of the requested information. I understand that I may be charged a reasonable and cost based fee.

____ I understand that Edward T. Wolanski MD PC will provide information within 15 days from receipt.

You will receive notification regarding this access request no later than 30 days from date received. There are limited circumstances on which your request may be denied, some of which you may have the right to request a review of the decision.

_____ Date_____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Forward this request to Privacy Officer or Office Manager