



College Park Family Care Center

Request to Review/Receive Health Care Information

1. You have the right to inspect and/or have a copy of your health care information, or that of an individual for whom you are a legal guardian.
2. We will review the information you are requesting and will determine based on HIPAA guidelines, whether to permit you to examine the requested health care information. In some cases as outlined by HIPAA, we may refuse permission. Legal reasons for refusing permission include, but are not limited to: (a) we feel the request is false or misleading or (b) we feel that it could cause harm to you or to someone else.
3. If you have requested to review your records and we have approved your request, we will make an appointment with you to review your health information. There will be a minimum fee of \$18.00. We will let you know of the charges prior to setting your appointment.
4. We are allowed under HIPAA to charge for records processing. We charge \$18.97 labor/supply flat fee. Additionally, \$.63 per page up to 250 pages and \$.45 per page for each page over 250 pages will be charged. If you request that copies of your health information be mailed to you, appropriate postage will be charged.
5. If you are requesting to receive your records, once approved, you will be contacted by **DataFile Technologies**, our copy service, regarding the fees that must be received prior to the release of your health information.
6. If you are requesting to review your records, once approved, CPFCC Central Medical Records Department will monitor the review unless the provider has requested to do it. You will be contacted regarding setting up the appointment,

Please **fax** this completed form to (913) 338-1311 or **mail** the form to:

College Park Family Care Center Attn: Centralized Medical Records
11755 W 112th St. Suite 201, Overland Park, KS 66210

To set up an appointment to review your records please complete below:

Name:		Date of Birth:
Address:		Phone:
City:	State:	Zip Code:
<input type="checkbox"/> I wish to review the entire record		
<input type="checkbox"/> I wish to review the following from my record (please indicate below):		

To get a copy of your records please complete below:

Name:		Date of Birth:
Address:		Phone:
City:	State:	Zip Code:
<input type="checkbox"/> I wish to receive the entire record (this is the last 2 years unless otherwise specified)		
<input type="checkbox"/> I wish to receive a copy of the following from my record (please indicate below):		
<input type="checkbox"/> I wish to receive the above request in an electronic form.		
By law, we have 30 business days to get you this information, if approved by your provider. However, if you need this information prior to that date, you can indicate that date here:		

I certify that the information provided above is true and complete to the best my knowledge and the health care provider has the right to rely on the information provided. I agree to pay the incurred expenses as outlined above.

Printed Name of Patient

Date

Signature of Patient or Patient's Representative

Relationship to Patient

<input type="checkbox"/> Approved to review <input type="checkbox"/> With Staff Fee \$18.00 <input type="checkbox"/> With Provider Fee _____	<input type="checkbox"/> Approved to release	<input type="checkbox"/> Denied for review <input type="checkbox"/> Reviewable <input type="checkbox"/> Unreviewable Date Denial Letter Sent _____
Provider Signature/Date		
Review Appointment Date	Signature of Staff Present for Review	