NEUROSURGICAL ASSOCIATES, INC.　　　STEPHEN F. CALDERON, MD

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Tel (860) 522-7121 – Fax (860) 244-3516

Request for Access to Protected Health Information

Patient's Name: _____
Address: _____
_____
Date of Birth: _____
Phone: _____

☐ I hereby request that Neurosurgical Associates, INC. provide me with:

☐ Access to the protected health information/medical record for the above patient.

☐ A copy of the medical record for the above patient.

Copies of the following protected health information:

_____
_____
_____

I understand that Neurosurgical Associates, INC. will provide me with access within 30 days of receipt of this written request for access, with the following exceptions:

- If Neurosurgical Associates, INC. received the request less than 30 days after the patient's discharge, Neurosurgical Associates, INC. will furnish the requested record upon completion of the record.

- If the protected health information ("PHI") I am seeking is in an alternative format (such as a computer disc) or in summary format, and Neurosurgical Associates, INC. is unable to respond within the normal 30 day period, Neurosurgical Associates, INC. can take an additional 30 to respond (but will inform me in writing within 30 days of the delay).

I understand that if access to my medical record is granted, Neurosurgical Associates, INC. may impose a reasonable, cost-based fee of $.45 per page, plus postage for any copies of my protected health information or an explanation or summary of such information.

If I am denied access to my protected health information, I understand that I have the right to have the Neurosurgical Associates, INC. decision reviewed, and may make a complaint to Neurosurgical Associates, INC. or the Secretary of Health and Human Services.

Signature of Person Making Request: _____

Date: _____