WESTSIDE ORTHOPAEDICS

PATIENT REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

Patient Name _____Date of Birth
Social Security Number _____Date of request

INFORMATION REQUESTED

- Medical Records
- billing Records
- Other

DATES REQUESTED _____ through

ACCESS REQUESTED

- **Copies of requested information** - I understand that Westside Orthopaedics may charge a fee for the costs of copying, mailing or other supplies associated with my request.

  - I will pick the records
  - Please mail the information to:

  _____

  _____

^ **Inspection of my heath information at Westside Orthopaedics** - please contact the Record Department to arrange a mutually convenient time for inspection at:

Westside Orthopaedics
4005 Westmark Dr. Ste. 200
Dubuque, Iowa 52002
563-582-6202

_____

Signature of Patient or authorized Representative
Date
If signed by authorized representative, print name and relationship below

_____

Print Name
Relationship

forms\req for PHI