Request for Patient Access to Health Information

I, (print name) _____ Date of Birth_____/_____/_____ hereby request to inspect or obtain a copy of my medical records from Vail Summit Orthopaedics and Neurosurgery (VSON). Under federal law 104-191, known as HIPAA, I am entitled to such access upon written request. **Under Colorado State law, VSON has 15 calendar days to fulfill my request.**

SECTION 1

I would like to:

☐ Obtain a copy of my Personal Medical ***IMAGES*** **please complete **section 2***

☐ Obtain a Copy of my Personal Medical ***RECORDS*** **please complete **section 2***

☐ Allow (print name) _____ to access my Personal Medical Records until further notice.

Choose one or both: □ Verbal Discussion with team/provider. □ May obtain printed records on my behalf.

☐ Access and Inspect my Personal Medical Records (Done in Medical Office)

Please choose one:

□ All of the medical Records

□ The portion of the Records Concerning: _____

SECTION 2

I request that confidential communications be sent via one, or multiple, of the following means:

☐ Send ***IMAGES*** **electronically** via PowerShare to Email or Practice Location (for **Medical Locations**): _____

☐ Send ***IMAGES*** **electronically** via Efferent Smart Share to Email (for **Patients**): _____

☐ Send ***RECORDS*** **electronically** via E-Mail or FAX (***quickest!***): _____

☐ Send ***RECORDS*** to an address via USPS, UPS, FedEx or Registered Mail

Address: _____

☐ Pick up ***RECORDS*** at the □ Vail □ Frisco □ Edwards

***PLEASE NOTE THAT YOU MAY REQUEST TO HAVE YOUR HEALTH INFORMATION SENT VIA ANY OF THE ABOVE MEANS, HOWEVER YOU MUST INITIAL EACH OF THE FOLLOWING:**

____ *I understand that having my personal health information sent via any of the following means put my information at greater risk of being disclosed to unintended parties as no fault of Vail Summit Orthopaedics and Neurosurgery.*

_____ *With this request, I agree that the security and confidentiality of my confidential medical information that is sent to an alternate address or via an alternate means is my responsibility alone. If Vail Summit Orthopaedics and Neurosurgery acts on my requests and sends communications as I have specifically directed them to do in writing. I agree that Vail Summit Orthopaedics and Neurosurgery cannot and shall not be responsible for any inadvertent disclosures that may occur as a result of fulfilling my written request.*

_____ *Under federal law, Vail Summit Orthopaedics and Neurosurgery is required to accommodate "reasonable" requests for communicating confidential medical information to me via alternate means. They may deny my request if they determine that my request is unreasonable.*

_____ *If an expense is involved in fulfilling my request, I will be charged at the expense. If the expense involved is unreasonable or burdensome, Vail Summit Orthopaedics and Neurosurgery may deny my request on that basis alone.*

Signed: _____ **Date:** _____

Print Name: _____ **Telephone:** _____

If not signed by the patient, please indicate your relationship to the patient:

□ Parent or Guardian or conservator for an incompetent patient

□ Beneficiary or personal representative of deceased patient

□ Other (specify) _____

Your Name: _____ Date: _____ Telephone: _____

If you have questions on how to properly fill in this form, please call 970-477-7432

Once complete please fax this form to 866-725-4659 or email it to roi@vsortho.com or drop it by a VSON location