Medical Records Request Form

Rania Abdel-Rahman, MD, PLLC DBA Kidney Medical Care
4168 Southpoint Pkwy, Suite 103, Jacksonville, FL 32216
Tel (904) 551-1185 -- Fax (904) 551-1184

Patient's Legal Name _____
First **Middle** **Last**

Home Address:
Street _____
City _____
State _____
Zip Code _____
Date of Birth (MM/DD/YYYY) _____
Last 4-Digits of Social Security No **XXX-XX-** _____
Home Telephone _____
Mobile Telephone _____
Work/Other Telephone _____
Fax _____
E-Mail _____

I hereby request that Kidney Medical Care (The Practice) provide me with the following (Check all applicable items):

_____ My Complete Medical Records

_____ Any other personally identifiable personal information used by the Practice to make medical decisions about me

Please check one of the following items:

_____ I am only interested in accessing or obtaining copies of the Requested Information related to the time period:

From (MM/DD/YYYY) **To (MM/DD/YYYY)**

_____ I am only interested in accessing or obtaining copies of all Requested Information maintained by the Practice

Reason for the request (Check all that applies):

_____ Treatments/Continued Care
_____ Payment/Billing
_____ Legal/Administrative

_____ Other (Please Explain) _____

I understand that any information provided to me pursuant to this request will not include (i) information required in reasonable anticipation of (or for use in) a civil, criminal, or administrative proceeding or as may otherwise be required as applicable by law, or (ii) if I am the parent or legal guardian requesting access to a minor's information, records related to certain categories of treatment as required by law (for example, a minor treatment for venereal disease, the performance of abortion operation, or care or treatment to which the minor is permitted to consent-without needing to obtain his/her parent's/guardian's consent first-and has so consented, for example, HIV testing, STD diagnosis and treatment, chemical dependence treatment, prenatal care, care received by a married minor, and contraception and/or family planning services)

I understand that the Practice may deny this request under limited circumstances permitted by federal regulations governing the protection of personally identifiable health information. I further understand that, except as otherwise permitted under applicable federal law, I have the right to have a denial for my request reviewed by a licensed health care practitioner selected by the Practice who did not participate in the Practices request to deny my request. If my request is denied again, I have the right to have such denial reviewed by medical records access review committee appointed by the Department of Health of the Sate of Florida

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I understand that the Practice will notify me of its decision to approve or deny my request to access or obtain copies of the Requested Information within (30) thirty days of receiving this request if the information is maintained or accessible on-site at the Practice or within (60) sixty days if the Requested Information is not maintained or accessible on-site at the Practice. If the Practice is not able to comply with my approved request within the applicable time limit, it may extend the applicable deadline for up to (30) thirty days by notifying me in writing.

I would prefer to:

_____ Pick-up or view the Requested Information at Kidney Medical Care located at 4168 Southpoint Pkwy, Suite 103, Jacksonville, FL 32216

_____ Have a copy of the Requested Information mailed to me at the following address:

Street _____

City _____

State _____

Zip Code _____

I understand that the Practice will charge **[$0.75] per page up to 25 pages and [$0.25] per page for additional pages**, for copying fees. There's no charge for viewing or reading the records at the Practice. Postage fees may apply for mailing the Requested Information.

I understand that the protected health information specified below may include mental health, substance abuse (e.g., drugs, alcohol) HIV/AIDS status information, diagnostic and treatment records.
I have read and understand the following statements:
1. I may revoke this authorization at any time by notifying the Practice in writing.
2. I understand that my revocation does not affect any disclosure made prior to the revocation being received and processed.
3. I understand the information disclosed may be subject to redisclosure and no longer be protected by federal or state privacy laws.
4. I understand that I am signing this form voluntarily and I am signing this under my own free will. The Practice will not condition my treatment, payment enrollment in health plans or my eligibility for benefits by signing this form.
5. I further agree to pay charges to provide the information request per Florida Statute
6. I understand that unless otherwise revoked, this authorization will expire upon the following date, event or condition: _____.
If no expiration date, event or condition is noted this authorization will expire 1 year from the date signed.

_____ _____
Signature of Patient **Date**

I understand and agree to the provisions of this form on behalf of the individual indicated above to be the patient. I have signed my name individually as the representative of the patient and have attached a copy of the court order designating me as the guardian of the patient, or documentation designating me as the Legally Authorized Person (LAP) of the patient.

_____ _____
Signature of Representative (If Any) Date

_____
Printed Name of Representative (If Any)

After completing and signing this form, please return it to:

By Mail: Kidney Medical Care
Rania Abdel-Rahman, MD, PLLC
4168 Southpoint Pkwy, Suite 103
Jacksonville, FL 32216

Or, By Fax: (904) 551-1184