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Cottage Grove Cardiology, P.C.
Specializing in Cardiovascular Medicine

Julian Esteban, MD, MS, FACC
Jawad Haider, MD, FACC
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Erin Vincent, PA-C
Jason Cornelio, PA-C

REQUEST FOR ACCESS TO AND/OR OBTAINING A COPY OF PHI

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), you have a right to request the opportunity to inspect and/or obtain a copy of your health information, referred to by the Practice as its Designated Record Set. If you are requesting a copy of your information, we have a right to impose a reasonable fee to compensate us for the cost of fulfilling your request (e.g., copying, labor and postage). ***Connecticut state law permits us to charge a $.65 per page. This fee is all inclusive of labor and copying. Postage is additional. Unless otherwise specified, only the most recent findings, progress notes and test results will be provided. There is no charge for Veterans.***

☐ I am hereby requesting to inspect and/or obtain a copy of my health information pertaining to me, maintained at the Practice.

☐ I am the legal representative for the patient mentioned below. I am hereby requesting to inspect and/or obtain a copy of his/her health information maintained at the Practice. **Legal documentation (ie. health surrogate, court order, living will) must be provided to us if you are not the patient.**

☐ I request that my medical records be sent to me via email. I acknowledge that personal information sent by email is not encrypted and CGC is not responsible if my information is obtained by a third party.

☐ Check if records are to be picked up.

Patient Name: _____ Date of Birth: _____

Address to send medical records: _____

_____

Email address: (if requesting documents to be emailed) _____

_____ _____ _____
Signature of Patient or Representative Printed Name of Patient or Representative Date

I understand that once my medical records are mailed or picked up that liability is released for Cottage Grove Cardiology, PC for lost or stolen records. Medical records will be sent U.S. Postal mail unless otherwise requested.

PRACTICE REVIEW SECTIONS:

Reviewed by:	Review date:

REVOCATION SECTION

I hereby revoke this authorization, effective _____/_____/_____.

_____ _____
Patient Signature Date

_____ _____
Printed Name of Patient Birthdate

_____ _____
Signature of Practice Privacy Officer Date

If the practice is seeking this authorization from you for a use or disclosure of you PHI, we will provide you with a copy of this signed authorization.