ORTHOPEDIC SURGICAL PARTNERS
ORTHO SPEED PASS

# Request For Access To Protected Health Information

**PATIENT NAME:** _____ **D.O.B.:** _____

**ADDRESS:** _____ **PHONE:** _____

**I am requesting access to my protected health information that is currently maintained by Orthopedic Surgical Partners, PC (OSP).**

**I would like to access my protected health information by (check all that apply):**

_____ Inspecting my protected health Information. If my request is approved, OSP will contact me at the address listed above to instruct me how to arrange for a convenient time and location to inspect my requested protected health information.

_____ Obtaining a copy of my protected health information.

Would you accept a summary or explanation of your protected health information in lieu of access? **Yes / No**

_____ If my request is approved, OSP will mail my requested protected health information to the address listed above.

_____ If you prefer to pick up your information from HOS during normal business hours, please check here _____ .

**I request the following access to my protected health information:**

_____ All of my protected health information.

_____ Some of my protected health information as follows:

(Include specific dates, etc. to assist OSP in providing access to a portion of your Information.)

_____

**I understand that my rights with regard to this request for access are set forth in OSP's Notice of Privacy Practices.**

**By signing this form, I agree to pay the reasonable costs of preparing, copying, mailing or other supplies and labor associated with my request, up to the maximum allowed by law.**

**Patient Signature:** _____ **Date:** _____

**Printed Name:** _____