Request for Access/Records Release

Louscher Family Dentistry, LLC Privacy Official Name: Kate Samp Telephone: 515-295-2334 or 712-852-2054

Patient's Name (print): _____ Date of Birth: _____ (for identification purposes)

Describe the records you wish to access/release: _____

What would you like for us to do for you?

- ☐ If you would like the information emailed, enter the email address here (PLEASE PRINT VERY CLEARLY!): _____@_____

  We do not recommend sending patient information in an unencrypted email because third parties may be able to access the email.

- ☐ I want you to mail the copy of the requested records to:

  Name: _____

  Address: _____

- ☐ I wish to see the requested records.
- ☐ I wish to get a copy of the requested records.
- ☐ If the requested records are in an electronic designated record set, I wish an electronic copy of the requested records the following form and format, if readily producible:_____

If the request is by a patient:

Patient Signature: _____ Date: _____

If the request is by a patient's personal representative:

Print the Name of the Personal Representative: _____

Relationship to the Patient: (Self, parent, spouse, guardian, other) _____

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

Signature of Personal Representative: _____ Date: _____

Fees

Our practice may charge a reasonable, cost-based fee to for copies of patient information, cost of electronic media (blank CD or USB drive) and for postage to mail records if requested.

Questions

Please contact our privacy official listed at the top of this page if you have any questions about your request to inspect or copy records.

For dental office use only:

- ☐ Request for access denied (attach written denial).
- ☐ Request for access approved.

If approved, describe below when and how access was provided.
