FIU MMC Faculty Group Practice
Green Family NeighborhoodHELP
Linda Fenner 3D Mobile Mammography Center
Health Information Management – Medical Records Request
800 SW 108th Ave., Suite 100, Miami, FL. 33174
Ph. # (305) 348-5238 Fax # (833) 902-3983

PATIENT ACCESS REQUEST

Patient Information:

Print Patient Name: _____Date of Birth: _____
Other Names Used: _____
Phone # _____ Email: _____
Street Address: _____
Apt/Unit #: _____ City: _____ State: _____ Zip Code: _____
Name of Legal Representative (if other than patient): _____
☐ Parent ☐ Guardian ☐ Other: (explain) _____

I am making this request on behalf of:

☐ Myself
☐ A Patient who is a Minor, as the Minor's Parent or Legal Guardian
☐ A Patient, as the Patient's Personal Representative

I would like to:

☐ Receive the requested file via electronic media (If readily producible) ☐ Patient Portal ☐CD ☐Thumb-drive (USB)
☐ Receive a hardcopy of the requested medical records. ☐ Inspect/Review the medical records (In-person)
☐ Receive a summary or explanation of the medical information ☐Other: _____
☐ Provide record information to Name/Organization _____
_____

I would like the requested information/summary or explanation/Thumb-drive/CD delivered via:

☐ Patient Portal
☐ In-person pickup
☐ US Mail to the following address above OR to: _____
☐ Facsimile #_____
☐ Verbal Disclosure (please specify what information below)
☐ Email communication at: _____

I would like to obtain the following information:

☐ All records for the period from: (_____/_____/_____) **TO** (_____/_____/_____) OR ☐ **All**
☐ All records covering a specific condition, injury, or treatment: _____
☐ All records created by an individual health care professional: _____
☐ Other: _____

I understand that Florida International University (FIU) may charge the actual, average, or flat fee to produce the requested information, including but not limited to postage, cost of thumb-drive, cost of CD, and if my request includes a summary or explanation, FIU may charge me for the time required to prepare the summary or explanation I have requested. The estimated fees are: _____.
I understand that if I check the "Inspect/Review" box above that I will need to schedule an appointment with my healthcare provider to review the information specified to be Inspected/Released.
I understand that this request for access/release of information may be denied or reduced and only portions released. If denied, I may have the right to request the denial be reviewed by another healthcare provider that FIU designates by submitting my request in writing to the Privacy Coordinator.
I understand that I have the right to file a written complaint concerning any final denial for access within 180 days of my receipt of my denial to: Director of Compliance and Privacy for Health Affairs. 11200 S.W. 8th Street. Modesto A. Maidique Campus, AHCA 4 216. Miami, FL 33199

_____ _____
Signature of Patient or Patient's Legal Representative **Date**

For FIU Entities USE ONLY

Name and Title of FIU Workforce member who received the verbal/written access request: Patient ID #: _____

Print Name_____ Title _____
Method the verbal access request was made: ☐ Telephone ☐ In-person ☐ Other: _____

Date verbal/written request received: _____ Date Access Granted: _____
Extension requested: ☐ Yes ☐ No
If yes, give reason for extension request: _____