PAIN DIAGNOSIS – JOHN A. CAMPA III, MD
1701 MOON ST. NE ▪ SUITE 100 ▪ ALBUQUERQUE, NM 87112 **TEL (505) 508-1543 / FAX (505) 554-2118**
http://paindiagnosis.net help@paindiagnosis.net

HIPAA: Patient Records Access Form

Patient Name:_____

Date of Birth: _____ Patient SSN: _____

Request regarding my protected heath information (PHI) at the practice of John A. Campa III, MD:

- Inspect: ___
- Obtain a copy: ___
- Inspect and obtain a copy: ____

INSPECTION

I would like to visually inspect the following:

My complete record: ___

My record for the time period: _____ through _____

Specific section(s) of my record. Describe:

_____

_____

I would like to inspect my records on the following date and time:

RECEIVING A COPY

I would like to receive a copy of the following:

My complete record: ___

My record for the time period: _____ through _____

Specific section(s) of my record. Describe:

_____

_____

I would like to receive a copy in the form of:

Readable paper copy: ___

Readable summary in lieu of receiving the complete record: ___

Other format agreed upon by myself and the practice of John A. Campa III, MD: Describe:

I would like to pick up the copy of my records on the following date and time: _____

Please mail the copy of my records to: _____

ATTESTATION:

My signature below is my agreement in advance that I am responsible for any copying, labor, supplies or mailing fees incurred by the practice of John A. Campa III, MD to fulfill my request.

The practice of John A. Campa III, MD has the right to deny access in whole, or in part to your protected health information if the records are psychiatric notes, are a matter of national security or public health policy, are part of a legal proceeding, are provided by a non-provider under promise of confidentiality concerning their identify or could place in danger your life or the lives of others.

_____ _____

Signature of Patient & Date

_____ _____

Personal Representative of Patient & Date

_____

Relationship to Patient