First Internal Medicine, Prof. LLC
Comprehensive medical care for adults
TIN: 26-2998271

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REQUEST TO RECEIVE A COPY OF MEDICAL RECORDS FOR PERSONAL USE

Patient Name _____ DOB: _____

I wish to receive a copy of my medical records specified in the attached Authorization for personal use.

First Internal Medicine stores some or all the records as electronic health records in compliance with all applicable federal and state privacy and security regulations.

First Internal Medicine offers the following options for me to receive my records:

(1) I wish to receive the records as **PDF files on CD** for a **flat fee of $50** which includes postage. If I choose this option, records will be copied and CD mailed to me via USPS Priority Mail within 30 days after First Internal Medicine receives the signed Authorization (page 2) and payment form (this page).

(2) I would like to receive **printed hard-copy** of the records. If I chose this option, I will mail the Authorization to release the records to myself to First Internal Medicine. Within 30 days, First Internal Medicine will prepare the paper copy of my records and notifies me of the **payment due based on the page count and postage**. Upon receipt of payment, the records will be mailed to me via USPS Priority Mail without any further delay.

*** PLEASE CIRCLE ONE OF THE OPTIONS ABOVE***

IF YOU CHOOSE OPTION 1, PLEASE FILL THIS SECTION AND RETURN TO OUR OFFICE:

I attach the payment of $50 for medical records copy fee. Check number _____.

OR

I authorize the charge of $50 to my VISA or MasterCard (sorry, no AmEx). My information is -

Name as printed on the card: _____

Credit card number: _____ Expiration: _____ / _____

Billing ZIP code: _____ Security code (CVC2, 3 digits) on the back of the card: _____

Signature of the card holder: _____

Please mail this form and payment to: First Internal Medicine
5950 South Willow Drive, Suite 212
Greenwood Village, CO 80111

Name of Practice: First Internal Medicine, Prof . LLC – Igor Huzicka, MD

Authorization to Receive a Copy of Medical Records for Personal Use

Patient name: _____ Date of birth: _____

Previous name (if applicable):_____

Please forward to me a copy of my medical records with the following health care information (check all that apply):

- ❒ All my health information maintained by the above-named practice
  (Circle "include" or "exclude" for each of the following)
  Include or Exclude My health information related to alcohol or drug abuse
  Include or Exclude My health information related to HIV/AIDS
  Include or Exclude My health information related to genetic testing
  Include or Exclude My health information related to psychological or psychiatric conditions
  (Please note that you do not have the right of access to psychotherapy notes)
- ❒ My health information relating to the following treatment or condition: _____
- ❒ Limit disclosure of my health information to the following dates: From _____ To _____
- ❒ Other: _____

Please mail my records to the following address:

Name (if different from patient's name, c/o): _____

Street: _____ City:_____ State: _____ Zip:_____

Reason(s) for this authorization (check all that apply):

- ❒ Transfer of care to a new physician.
- ❒ Other (please specify): _____
- ❒ I do not wish to specify.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient If signed behalf of patient, please indicate legal authority to receive records (parent, legal guardian, power of attorney, etc.)