NeuroCare
CENTER FOR SLEEP

Request by Patient to Access Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 establishes an individual's right to access and receive copies of their protected health information (PHI). Neurocare, Inc. requires that all requests for access and copies be made in writing using this form. Neurocare, Inc.'s Privacy Officer will review all requests. Neurocare, Inc. has thirty days to respond to your request. Neurocare can obtain an additional thirty days to complete this request with prior notice to you. This may be requested in cases where your information may not be active and is stored off-site in archives.

Patient Name: _____

Patient Date of Birth: _____

Date of Request: _____

Requested Information:

Please provide specific details and dates:

_____

_____

How would you like to receive your results?

( ) U.S. Mail – Provide address: _____

( ) Fax – Provide Fax #: _____

( ) ***Email* – Provide Email Address: _____

***By signing below, I acknowledge that I understand the potential risks associated with transmitting my protected health information through non-secure email.*

Patient Signature (or authorized individual) _____

If authorized individual, relationship to patient _____

Return this completed form to:

Neurocare,Inc.
70 Wells Avenue, Suite 201
Newton, MA 02459
Attn: Privacy Officer

Or Fax: 617-796-9099

For practice use only

NEUROCARE, INC.

□ Accepts □ Denies □ Accepts in part (see comments below)

Privacy Officer Signature:

_____

Date of Review:

_____

Comments:

_____